DOES NOT CIRCULATE

UNIVERSITY OF MICHIGAN
JUN 24 1959
MEDICAL LIBRARY

Arizona Medicine

Journal of
ARIZONA MEDICAL ASSOCIATION

Arizona Medical Association

Official Journal

Medical Society of the United States and Mexico.

DARVON® COMPOUND

(dextro propoxyphene and acetylsalicylic acid compound, Lilly)

lifts the burden of pain

1 or 2 Pulvules® three or four times daily

Narcotic prescription *not* required

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

Lilly

920295

TABLE ON CONTENTS—PAGE 5A & 6
DIRECTORY 7A & 8

Vol. 16, No. 6 • JUNE, 1959 •

helps them weather the hay fever season

BENADRYL®

ANTIHISTAMINIC-ANTISPASMODIC

gives fast, comprehensive relief of allergic symptoms. *At this time of year pollens from trees, grasses, or weeds cause distressing symptoms in allergic patients. You can help your patients to enjoy greater comfort during the hay fever season by prescribing* BENADRYL. *Its potent antihistaminic action rapidly relieves nasal blockage, rhinorrhea, sneezing, itching, and related allergic reactions, while its atropine-like antispasmodic action swiftly suppresses bronchial and gastrointestinal spasms.* BENADRYL *Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a variety of convenient forms including: Kapseals,® 50 mg. each; Kapseals, 50 mg., with ephedrine sulfate, 25 mg.; Capsules, 25 mg. each; Elixir, 10 mg. per 4 cc.; and Emplets,® 50 mg. each, for delayed action. For parenteral therapy,* BENADRYL *Hydrochloride Steri-Vials,® 10 mg. per cc.; and Ampoules, 50 mg. per cc.*

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

85089

ARIZONA MEDICINE
Journal of ARIZONA MEDICAL ASSOCIATION
Vol. 16, No. 6 — June, 1959

Table of Contents

OFFICERS DIRECTORY 7A
SPECIAL COMMITTEES 7A
INDEX TO ADVERTISERS 2A

ORIGINAL ARTICLES

THE VENEREAL DISEASE PROBLEM IN ARIZONA 417
Paul L. Singer, M.D., Phoenix, Ariz. & A. B. Pasternack, M.D., Tucson, Ariz.

DIAGNOSIS AND TREATMENT OF SYPHILIS 420
Evan W. Thomas, M.D., Albany, N. Y.

THE EPIDEMIOLOGIC CHAIN 425
Robert Lugar, Los Angeles, California

UNITED FRONT IN VD CONTROL 427
William J. Brown, M.D., M.P.H., Atlanta, Georgia

EDITORIAL SECTION

ANNUAL MEETING ATTENDANCE 432
PROGRESSIVE ACTION 433
QUALITY MEDICAL CARE 433
LETTER TO THE EDITOR 434
CORRECTION 434
SURGICAL FORUM OF GRADUATE SURGEONS 435
SURGICAL CONSIDERATIONS OF DISEASE OF THE LIVER 435
William A. Altmeier, M.D.
ADENOMA AND CARCINOMA OF THE THYROID 435
George Crile, Jr., M.D.

MEMORIAL

MEMORIAL TO DR. REDFORD A. WILSON 440

TOPICS OF CURRENT MEDICAL INTEREST

1958-1959 ANNUAL REPORT OF THE SECRETARY 441
1958-1959 ANNUAL REPORT OF THE LEGISLATION COMMITTEE 442

(Continued on Page 6A)

1958-1959 ANNUAL REPORT OF SOUTHWESTERN DISTRICT COUNCILOR 444
1958-1959 ANNUAL REPORT OF THE MEDICAL ECONOMICS COMMITTEE.....445
1958-1959 ANNUAL REPORT OF THE MEDICARE COMMITTEE 446
1958-1959 ANNUAL REPORT OF THE FEE & CONTRACTUAL MEDICINE COMMITTEE 447
1958-1959 SUPPLEMENTAL ANNUAL REPORT OF THE FEE & CONTRACTUAL MEDICINE COMMITTEE 449
1958-1959 ANNUAL REPORT OF THE AD HOC COMMITTEE ON POISONING CONTROL 449
1958-1959 ANNUAL REPORT OF THE INDUSTRIAL RELATIONS COMMITTEE....453
RESOLUTIONS SUBMITTED, 1959 MEETING 458
INTERPROFESSIONAL CODE FOR PHYSICIANS & ATTORNEYS 458
SOCIALIZED MEDICINE – ITS AVOIDANCE THROUGH NON-PARTICIPATION..460
DIABETES SURVEY BY STATE DEPARTMENT OF HEALTH 460
ARIZONA POISONING CONTROL INFORMATION CENTER.....462
PASSANO FOUNDATION AWARD FOR 1959 464
ARIZONA STATE SOCIETY OF ANESTHESIOLOGISTS 464
BLUE SHIELD 466
BLUE CROSS – BLUE SHIELD 467
LOCATION OPPORTUNITIES 468
LOCATION INQUIRIES 469

FUTURE MEETINGS

FETAL ELECTROCARDIOGRAPHY, Univ. of Calif., Los Angles 472
OFFICE UROLOGY, Univ. of Calif., Los Angeles 472
SURGICAL TECHNIQUE, Univ. of Calif., Los Angeles 472
PEDIATRIC CARDIOLOGY, Seminar, Univ. of Calif. 472
EMOTIONAL PROBLEMS IN OFFICE PRACTICE, Seminar, Univ. of Calif. 472
INTERNAL MEDICINE, Seminar, Univ. of Calif. 472
AMERICAN CANCER SOCIETY, CALENDAR NATIONAL MEETINGS 473
CALENDAR OF NATIONAL MEETINGS 473

DIRECTORY

LABORATORIES 59A
DRUGGISTS – SANATORIUM DIRECTORY 61A
PHYSICIANS' DIRECTORY 63A

Published monthly by the Arizona Medical Association, Inc. Business office at 801 N. 1st Street, Phoenix, Arizona. Subscription $5 a year, single copy 50 cents. Entered as second class matter March 1, 1921, at Postoffice at Phoenix, Arizona, Act of March 3, 1879.
ARIZONA MEDICINE JOURNAL covered by copyright and all rights reserved. Permission to reproduce articles in whole or in part must be obtained in writing from the publisher. The reproduction for commercial purposes of articles in Arizona Medicine will not be permitted.
(The Editors of the Journal assume no responsibility for opinions expressed in the articles contributed by individual members.)

Directory

THE ARIZONA MEDICAL ASSOCIATION, INC
Organized 1892 826 Security Building
234 NORTH CENTRAL AVE., PHOENIX, ARIZONA

OFFICERS AND DIRECTORS

Dermont W. Melick, M.D. .....President
1005 Professional Building, Phoenix, Arizona
Lindsay E. Beaton, M.D. .....President-Elect
1650 N. Campbell Avenue, Tucson, Arizona
Leslie B. Smith, M.D. .....Vice President
1130 East McDowell Rd., Phoenix, Arizona
Lorel A. Stapley, M.D. .....Secretary
550 West Thomas Rd., Phoenix, Arizona
Clarence E. Yount, Jr., M.D. .....Treasurer
105 North Cortez, Prescott, Arizona
Paul B. Jarrett, M.D. .....Speaker of the House
2021 N. Central Avenue, Phoenix, Arizona
Jesse D. Hamer, M.D. .....Delegate to A.M.A.
910 Professional Building, Phoenix, Arizona
Robert E. Hastings, M.D. .....Alternate Delegate to A.M.A.
1014 North Country Club Rd., Tucson, Arizona
Darwin W. Neubauer, M.D. .....Editor-in-Chief
720 North Country Club Rd., Tucson, Arizona

DISTRICT DIRECTORS

Frank W. Edel, M.D. .....Central District
738 E. McDowell Rd., Phoenix, Arizona
Donald A. Polson, M.D. .....Central District
550 West Thomas Rd., Phoenix, Arizona
E. Henry Running, M.D. .....Central District
150 W. McDowell Rd., Phoenix, Arizona
Paul L. Singer, M.D. .....Central District
1313 North Second Street, Phoenix, Arizona
Leo L. Tuveson, M.D. .....Central District
550 West Thomas Rd., Phoenix, Arizona
Donald F. DeMarse, M.D. .....Northeastern District
Box 397, Holbrook, Arizona
Roy O. Young, M.D. .....Northeastern District
110 West Birch Ave., Flagstaff, Arizona
Deward G. Moody, M.D. .....Southeastern District
101 Terrace Street, Nogales, Arizona
Walter T. Hileman, M.D. .....Southern District
20 East Ochoa, Tucson, Arizona
William B. Steen, M.D. .....Southern District
116 North Tucson Boulevard, Tucson, Arizona
James T. O'Neil, M.D. .....Southwestern District
113 West Second Street, Casa Grande, Arizona

DIRECTOR AT LARGE

W. R. Manning, M.D. .....Past President
770 North Country Club Rd., Tucson, Arizona

COUNTY MEDICAL SOCIETY OFFICERS FOR 1959

APACHE: Giles G. Merkel, M.D., President, McNary Hospital, McNary; Arnold H. Dysterheft, M.D., Secretary, McNary Hospital, McNary.

COCHISE: Fred L. Goff, M.D., President, 520 - 11th St., Douglas; George A. Spikes, M.D., Secretary, 720 - 11th St., Douglas.

COCONINO: Kent O. Hanson, M.D., President, 5 N. Leroux, Flagstaff; John F. Kahle, M.D., Secretary, 110 N. Beaver St., Flagstaff.

GILA: William E. Bishop, M.D., President, 230 S. Broad St., Globe; Ellis L. Pollock, M.D., Secretary, Miami Inspiration Hospital, Miami.

GRAHAM: Thomas W. Jensen, M.D., President, 626 Sixth Ave., Safford; Theodore O. Alexander, M.D., Secretary, 502 Third Ave., Safford.

GREENLEE: Hugh LaMaster, M.D., President, Box 1386, Clifton; T. L. Lothman, M.D., Secretary, Box 85, Morenci.

MARICOPA: Clyde J. Barker Jr., M.D., President, 710 Professional Bldg., Phoenix; Morris E. Stern, M.D., Secretary, 1313 N. 2nd St., Phoenix.

(Society Office: 2025 North Central Ave., Phoenix)

MOHAVE: Walter Brazie, M.D., President. Masonic Building, Kingman; Walter D. Bigford, M.D., Secretary, Masonic Building, Kingman.

NAVAJO: Myron G. Wright, M.D., President, 122 W. 3rd St., Winslow; Leo L. Lewis, M.D., Secretary, 101 S. Williamson, Winslow.

PIMA: Frederick S. Lesemann, M.D., President, 1627 N. Tucson Blvd., Tucson; Delmer J. Heim, M.D., Secretary, 116 N. Tucson Blvd., Tucson.

(Society Office: 37 E. Jackson Street, Tucson)

PINAL: Howard W. Finke, M.D., President, Magma Hospital, Superior; Thomas E. McCormick, M.D., Secretary, 321 W. Central Ave., Coolidge.

SANTA CRUZ: Zenas B. Noon, M.D., President, Gebler Building, Nogales; Charles S. Smith, M.D., Secretary, Gebler Building Nogales.

YAVAPAI: Ernest D. Geever, M.D., President, 533 W. Gurley St., Prescott; C. E. Yount Jr., M.D., Secretary, 105 N. Cortez St., Prescott.

YUMA: Paul J. Slosser, M.D., President, 450 W. 23rd St., Yuma; William J. Nelson, Jr., M.D., Secretary, 450 W. 23rd St., Yuma.

STANDING BOARDS – 1957-58

PROFESSIONAL BOARD: John R. Schwartzman, M.D., Chairman (Tucson); John F. Currin, M.D. (Flagstaff); Orin J. Farness, M.D. (Tucson); T. Richard Gregory, M.D. (Phoenix); Joseph M. Kinkade, M.D. (Tucson); Robert B. Leonard, M.D. (Phoenix); Charles S. Powell, M.D. (Yuma); Norman A. Ross, M.D. (Phoenix); Stuart Sanger, M.D. (Tucson); Milton C. F. Semoff, M.D. (Tucson); John M. Vivian, M.D. (Phoenix); Lowell C. Wormley, M.D. (Phoenix).

PUBLIC RELATIONS BOARD: Donald A. Polson, M.D., Chairman (Phoenix); Paul H. Case, M.D. (Phoenix); Max Costin, M.D. (Tucson); Walter T. Hileman, M.D. (Tucson); Paul B. Jarrett, M.D. (Phoenix); Herbert C. Kling, M.D. (Yuma); Deward G. Moody, M.D. (Nogales); Roy O. Young, M.D. (Flagstaff).

SPECIAL COMMITTEES – 1957-58

GRIEVANCE COMMITTEE: Carlos C. Craig, M.D., Chairman (Phoenix); Walter Brazie, M.D. (Kingman); W. Albert Brewer, M.D. (Phoenix); Robert E. Hastings, M.D. (Tucson); Walter T. Hileman, M.D. (Tucson); Oscar W. Thoeny, M.D. Phoenix); Otto E. Utzinger, M.D. (Scottsdale).

HISTORY AND OBITUARIES COMMITTEE: John W. Kennedy, M.D., Historian (Phoenix); Louis G. Jekel, M.D. (Phoenix); Darwin W. Neubauer, M.D. (Tucson); Howell S. Randolph, M.D. (Phoenix); Leslie B. Smith, M.D. (Phoenix).

INDUSTRIAL RELATIONS COMMITTEE: Philip G. Derickson, M.D. (Tucson); Francis M. Findlay, M.D. (San Manuel); Frederick W. Knight, M.D. (Safford); Kenneth G. Rew, M.D. (Phoenix); Leo L. Tuveson, M.D. (Phoenix).

LEGISLATION COMMITTEE: Reed D. Shupe, M.D., Chairman (Phoenix); Jesse D. Hamer, M.D., Chairman Emeritus (Phoenix); Walter Brazie, M.D. (Kingman); Charles T. Collopy, M.D. (Miami); Charles B Daniell, M.D. (Morenci); Arnold H. Dysterheft, M.D. (McNary); Orin J. Farness, M.D. (Tucson); C. Herbert Fredell, M.D. (Flagstaff); Carl H. Gans, M.D. (Morenci); Ray P. Inscore, M.D. (Prescott); Millard Jeffrey, M.D. (Phoenix); Charles H. Karr, M.D. (Safford); W. Shaw McDaniel, M.D. (Phoenix); Deward G. Moody, M.D. (Nogales); Donald E. Nelson, M.D. (Safford); Wallace A. Reed, M.D. (Phoenix); Alexander N. Shoun, M.D. (San Manuel); Paul L. Singer, M.D. (Phoenix); Lavern D. Sprague, M.D. (Tucson); Arthur C. Stevenson, M.D. (Phoenix); George C. Truman, M.D. (Mesa); Matthew L. Wong, M.D. (Yuma); MacDonald Wood, M.D. (Phoenix); Myron G. Wright, M.D. (Winslow); Paul V. Yingling, M.D. (Lowell).

MEDICAL DEFENSE COMMITTEE: Ernest A. Born, M.D., Chairman (Prescott); Preston T. Brown, M.D. (Phoenix); Harold W. Kohl, M.D. (Tucson).

MEDICAL ECONOMICS COMMITTEE: Frank W. Edel, M.D., Chairman (Phoenix); Ian M. Chesser, M.D. (Tucson); Paul B. Jarrett, M.D. (Phoenix).

PUBLISHING COMMITTEE: Darwin W. Neubauer, M.D., Chairman (Tucson); R. Lee Foster, M.D. (Phoenix); Frederick W. Knight, M.D. (Safford); Clarence L. Robbins, M.D. (Tucson).

SCIENTIFIC ASSEMBLY COMMITTEE: Dermont W. Melick, M.D., Chairman (Phoenix); Joseph Bank, M.D. (Phoenix); Lindsay E. Beaton, M.D. (Tucson); Hayes W. Caldwell, M.D. (Phoenix); Charles H. Karr, M.D. (Safford); Donald E. Nelson, M.D. (Safford); Darwin W. Neubauer, M.D. (Tucson); E. Henry Running, M.D. (Phoenix); Roland F. Schoen, M.D. (Casa Grande); Robert A. Stratton, M.D. (Yuma).

SPECIAL COMMITTEES – 1958-59

AIR POLLUTION COMMITTEE: George G. McKhann, M.D., Chairman (Phoenix); Bertram L. Snyder, M.D. (Phoenix).

ARIZONA AMEF COMMITTEE: Harold W. Kohl, M.D., Chairman (Tucson); Preston T. Brown, M.D. (Phoenix); James T. O'Neil, M.D. (Casa Grande); Abe I. Podolsky, M.D. (Yuma); Harold J. Rowe, M.D. (Tucson); E. Henry Running, M.D. (Phoenix).

BENEVOLENT AND LOAN FUND COMMITTEE: Ernest A. Born, M.D., Chairman (Prescott); Preston T. Brown, M.D. (Phoenix); Donald K. Buffmire, M.D. (Phoenix); Leslie B. Smith, M.D. (Phoenix); Clarence E. Yount, Jr., M.D. (Prescott).

BLOOD BANK COMMITTEE: Ralph H. Fuller, M.D., Chairman (Tucson); Zeph B. Campbell, M.D. (Phoenix); Paul J. Slosser, M.D. (Yuma).

CENTRAL OFFICE ADVISORY COMMITTEE: Clarence E. Yount, Jr., M.D., Chairman (Prescott); Dermont W. Melick, M.D. (Phoenix); James T. O'Neil, M.D. (Casa Grande); Leslie B. Smith, M.D. (Phoenix); William B. Steen, M.D. (Tucson).

CIVIL DEFENSE COMMITTEE: Ruland W. Hussong, M.D., Chairman (Phoenix); Richard O. Flynn, M.D. (Tempe); John W. Kennedy, M.D. (Phoenix); Robert M. Matts, M.D. (Yuma); Donald E. Nelson, M.D. (Safford); Darwin W. Neubauer, M.D. (Tucson); Roy O. Young, M.D. (Flagstaff).

CONSTITUTION AND BY-LAWS COMMITTEE: Carl A. Holmes, M.D., Chairman (Phoenix); Lindsay E. Beaton, M.D. (Tucson); Miguel A. Carreras, M.D. (Tucson); Paul B. Jarrett, M.D. (Phoenix); Dermont W. Melick, M.D. (Phoenix); Leslie B. Smith, M.D. (Phoenix).

FEE AND CONTRACTUAL MEDICINE COMMITTEE: Hayes W. Caldwell, M.D., Chairman (Phoenix); Lindsay E. Beaton, M.D. (Tucson); Frank W. Edel, M.D. (Phoenix); Francis M. Findlay, M.D. (San Manuel); Paul B. Jarrett, M.D. (Phoenix); James E. O'Hare, M.D. (Tucson); William B. Steen, M.D. (Tucson); Leo L. Tuveson, M.D. (Phoenix).

INSURANCE PLANNING COMMITTEE: Noel G. Smith, M.D., Chairman (Phoenix); Delmer J. Heim, M.D. (Tucson); Joseph

S. Lentz, M.D. (Phoenix); James E. O'Hare, M.D. (Tucson); Frank A. Shallenberger, M.D. (Tucson); Reed D. Shupe, M.D. (Phoenix); Paul L. Singer, M.D. (Phoenix).

LEGAL SERVICES COMMITTEE: Clarence E. Yount, Jr., M.D., Chairman (Prescott); Lindsay E. Beaton, M.D. (Tucson); R. Lee Foster, M.D. (Phoenix); Dermont W. Melick, M.D. (Phoenix); Wallace A. Reed, M.D. (Phoenix); Leslie B. Smith, M.D. (Phoenix).

MEDICAL SCHOOL COMMITTEE: Dermont W. Melick, M.D., Chairman (Phoenix); Walter Brazie, M.D. (Kingman); John R. Green, M.D. (Phoenix); Paul B. Jarrett, M.D. (Phoenix); Harold W. Kohl, M.D. (Tucson); Darwin W. Neubauer, M.D. (Tucson); Wallace A. Reed, M.D. (Phoenix); Clarence L. Robbins, M.D. (Tucson); Reed D. Shupe, M.D. (Phoenix); John F. Stanley, M.D. (Yuma); Oscar W. Thoeny, M.D. (Phoenix); Hugh C. Thompson, M.D. (Tucson.

MEDICARE ADJUDICATION COMMITTEE: Paul B. Jarrett, M.D., Chairman (Phoenix); Joseph Bank, M.D. (Phoenix); James D. Barger, M.D. (Phoenix); Lindsay E. Beaton, M.D. (Tucson); W. Albert Brewer, M.D. (Phoenix); Everett W. Czerny, M.D. (Tucson); Frank W. Edel, M.D. (Phoenix); Clarence C. Piepergerdes, M.D. (Phoenix); Robert A. Price, M.D. (Phoenix); E. Henry Running, M.D. (Phoenix); Stuart Sanger, M.D. (Tucson); Morris E. Stern, M.D. (Phoenix); Laddie L. Stolfa, M.D. (Phoenix); Ashton B. Taylor, M.D. (Phoenix); Charles E. Van Epps, M.D. (Phoenix).

MEDICARE COMMITTEE: Paul B. Jarrett, M.D., Chairman (Phoenix); Ernest A. Born, M.D. (Prescott); Frank W. Edel, M.D. (Phoenix); John A. Eisenbeiss, M.D. (Phoenix); Walter T. Hileman, M.D. (Tucson).

MEDICOLEGAL COMMITTEE: Ian M. Chesser, M.D., Chairman (Tucson); John R. Green, M.D. (Phoenix); Jesse D. Hamer, M.D. (Phoenix); Walter T. Hileman, M.D. (Tucson); William B. McGrath, M.D. (Phoenix); Robert A. Stratton, M.D. (Yuma).

NURSING SERVICES, JOINT COMMITTEE ON IMPROVEMENT OF: Bertram L. Snyder, M.D., Chairman (Phoenix); Francis J. Bean, M.D. (Tucson); Eleanor A. Waskow, M.D. (Phoenix).

OSTEOPATHY LIAISON COMMITTEE: Reed D. Shupe, M.D., Chairman (Phoenix); Sebastian R. Caniglia, M.D. (Phoenix); Abe I. Podolsky, M.D. (Yuma); Lorel A. Stapley, M.D. (Phoenix); Harry E. Thompson, M.D. (Tucson); Marcus W. Westervelt, M.D. (Tempe).

POISONING CONTROL, AD HOC COMMITTEE ON: Virginia S. Cobb, M.D., Chairman (Tucson); Frederick E. Beckert, M.D. (Phoenix); Maurice Rosenthal, M.D. (Phoenix); Martin S. Withers, M.D. (Tucson).

PROCUREMENT AND REASSIGNMENT COMMITTEE: Joseph M. Greer, M.D., Chairman (Phoenix); Arnold H. Dysterheft, M.D. (McNary); Francis M. Findlay, M.D. (San Manuel); Hilary D. Ketcherside, M.D. (Phoenix); Jesse B. Littlefield, M.D. (Tucson); Robert M. Matts, M.D. (Yuma); Joseph P. McNally, M.D. (Prescott); Donald E. Nelson, M.D. (Safford); William G. Schultz, M.D. (Tucson).

PROFESSIONAL LIABILITY INSURANCE INVESTIGATING COMMITTEE: Howard C. Lawrence, M.D., Chairman (Phoenix); Ernest A. Born, M.D. (Prescott); Jesse D. Hamer, M.D. (Phoenix); Paul B. Jarrett, M.D. (Phoenix); Stuart Sanger, M.D. (Tucson).

PROFESSIONAL LIAISON COMMITTEE: William B. Steen, M.D., Chairman (Tucson); Raymond J. Jennett, M.D. (Phoenix); Harold W. Kohl, M.D. (Tucson).

SAFETY COMMITTEE: MacDonald Wood, M.D., Chairman (Phoenix); Donald F. DeMarse, M.D. (Holbrook); John A. Eisenbeiss, M.D. (Phoenix); Paul B. Jarrett, M.D. (Phoenix); Henry P. Limbacher, M.D. (Tucson); Charles P. Neumann, M.D. (Tucson); Alvin L. Swenson, M.D. (Phoenix); Woodson C. Young, M.D. (Phoenix).

SCHOOL HEALTH, CO-ORDINATING COMMITTEE ON: Jack H. Demlow, M.D., Chairman, (Tucson); Trevor G. Browne, M.D. (Phoenix); Noel G. Smith, M.D. (Phoenix); Robert A. Stratton, M.D. (Yuma); Marcus W. Westervelt, M.D. (Tempe); Roy O. Young, M.D. (Flagstaff).

ADVISORY COMMITTEE TO THE WOMEN'S AUXILIARY: Melvin W. Phillips, M.D., Chairman (Prescott); Robert H. Cummings, M.D. (Phoenix); Hiram D. Cochran, M.D. (Tucson).

Women's Auxiliary

OFFICERS OF THE AUXILIARY TO THE ARIZONA MEDICAL ASSOCIATION – 1958-59

President ..... Mrs. Melvin W. Phillips
829 Flora Street, Prescott

President Elect ..... Mrs. Hiram D. Cochran
35 Camino Espanol, Tucson

1st Vice President ..... Mrs. Robert Cummings
5830 E. Arcadia Lane, Phoenix

2nd Vice President ..... Mrs. Robert A. Stratton
1916 - 6th Ave., Yuma

Treasurer ..... Mrs. Richard Hausmann
2639 East 8th Street, Tucson

Recording Secretary ..... Mrs. John K. Bennett
185 Sierra Vista Drive, Tucson

Corresponding Secretary ..... Mrs. Ray P. Inscore
Box 1511, Prescott

Director (1 year) ..... Mrs. Charles S. Powell
698 - 9th Ave., Yuma

Director (1 year) ..... Mrs. William E. Bishop
211 South 3rd Street, Globe

Director (2 years) ..... Mrs. Jay Sitterly
206 West Hunt Street, Flagstaff

STATE COMMITTEE CHAIRMEN – 1958-59

Chaplain ..... Mrs. James Moore
305 West Granada, Phoenix

Bulletin ..... Mrs. Albert J. Harris
Skyline Drive, Globe

Civil Defense ..... Mrs. John W. Kennedy
814 East Palmaire, Phoenix

Historian ..... Mrs. Roy Hewitt
130 Camino Miramonte, Tucson

Legislation ..... Mrs. Paul Causey
2200 North Alvarado Road, Phoenix

Parliamentarian ..... Mrs. George Enfield
335 West Cambridge, Phoenix

Public Relations–Community Service ..... Mrs. S. B. Silverman
334 East Medlock Drive, Phoenix

Safety ..... Mrs. Jay Sitterly
206 West Hunt Street, Flagstaff

Revisions ..... Mrs. Jesse D. Hamer
1819 North 11th Ave., Phoenix

Medical Education Fund ..... Mrs. Henry Hough
225 Yavapai Drive, Prescott

Newsletter ..... Mrs. John T. Clymer
201 West Flyn Lane, Phoenix

Nominating ..... Mrs. Charles S. Powell
698 - 9th Ave., Yuma

Publicity ..... Mrs. Juan E. Fonseca
2505 Indian Ridge Drive, Tucson

Mental Health ..... Mrs. Hubert R. Estes
6911 Soyaluna Place, Tucson

Finance ..... Mrs. James Soderstrom
Box 82, Whipple

Today's Health ..... Mrs. Frank Shallenberger
345 South Eastborne, Tucson

Recruitment–Paramedical Careers .. Mrs. Howard M. Purcell, Jr.
100 East Ocotillo Road, Phoenix

Student Nurse Loan Fund ..... Mrs. Harry T. Southworth
1107 Copper Basin Road, Prescott

COUNTY PRESIDENTS AND OFFICERS 1958-59

COCONINO COUNTY

President ..... Mrs. Roy O. Young
Box 1058, Flagstaff

Vice President ..... Mrs. C. Herbert Fredell
2108 North Talkington Drive, Flagstaff

Secretary ..... Mrs. John F. Currin
1214 North Navajo Drive, Flagstaff

Treasurer ..... Mrs. Kent Hanson
1210 Davis Way, Flagstaff

GILA COUNTY

President ..... Mrs. Charles T. Collopy
Box 623, Miami

Vice President ..... Mrs. A. J. Basse
135 North 6th Street, Globe

Secretary-Treasurer ..... Mrs. Jesse J. Jacobs
Box 1208, Miami

MARICOPA COUNTY

President ..... Mrs. Chester G. Bennett
30 West Ocotillo Road, Phoenix

President-Elect ..... Mrs. Thomas Rowley
114 South Miller, Mesa

1st Vice President ..... Mrs. Robert Leonard
3041 North Evergreen, Phoenix

Recording Secretary ..... Mrs. Robert Beers
202 West Flyn Lane, Phoenix

Treasurer ..... Mrs. Robert Gullen
5003 North 22nd Street, Phoenix

PIMA COUNTY

President ..... Mrs. Ian M. Chesser
414 North Country Club Road, Tucson

President-Elect ..... Mrs. Max Costin
2648 East 4th Street, Tucson

Vice President ..... Mrs. W. Stanley Kitt
2043 East 4th Street, Tucson

2nd Vice President ..... Mrs. George W. King
3239 North Stewart Avenue, Tucson

Secretary ..... Mrs. Elliot E. Stearns
2737 East 21st Street, Tucson

Treasurer ..... Mrs. Sherwood Burr
3135 Via Palos Verdes, Tucson

YAVAPAI COUNTY

President ..... Mrs. Chesley F. Blackler
506 Westwood Drive, Prescott

Vice President ..... Mrs. Ray P. Inscore
Box 1511, Prescott

Secretary ..... Mrs. Donald W. Merkle
Veterans Administration Center, Whipple

Treasurer ..... Mrs. Harry T. Southworth
1107 Copper Basin Road, Prescott

YUMA COUNTY

President ..... Mrs. Ralph T. Irwin
728 - 6th Ave., Yuma

Vice President ..... Mrs. William A. Phillips
633 - 8th Ave., Yuma

Secretary ..... Mrs. James Volpe, Jr.
1801 6th Avenue, Yuma

Treasurer ..... Mrs. Paul J. Slosser
701 8th Avenue, Yuma

ARIZONA MEDICINE
Journal of Arizona Medical Association

VOL. 16, NO. 6 JUNE, 1959

Original Articles

THE VENEREAL DISEASE PROBLEM IN ARIZONA

Paul L. Singer, M.D.(4)
Phoenix, Ariz.
A. B. Pasternack, M.D.(5)
Tucson, Ariz.

IN THE past 10 years there has been no significant change in the number of cases of syphilis that has been reported to the Arizona State Health Department. There has been a drop in primary, secondary, and early latent cases. These are contagious, or potentially contagious. There has been an increase in the reporting of late latent cases. In 1948 to '49, 1,304 cases of syphilis were reported, while in 1957 to '58, 1,548 cases were reported.(1) In the years between, at times there were a few more, at times there were a few less, but the rate has been fairly steady. It is interesting that there has been a drop in early cases reported and the rise in late cases reported by both private physicians and public institutions. The private physicians should keep abreast of the newer developments in the diagnosis and treatment of syphilis and also keep in mind the sociologic implications of the disease. Probably the chief factor in the drop in contagious cases and also the chief factor in transferring the treatment of some cases to the private physicians is the much greater ease of treatment with penicillin as compared to the older treatment with arsenic and bismuth.

During this same 10-year period, there has been a marked increase in the incidence of gonorrhea. In 1948 to '49, 1,049 cases of gonorrhea were reported to the state health department, whereas, in 1957-58 there were 2,524 cases. Apparently even though penicillin does cure gonorrhea a lot more simply than older methods of treatment, it seems that it has in no way solved the problem.

Arizona ranks fifth among the states and the District of Columbia in the number of cases of syphilis reported per 100,000 population.(2) Arizona reported 307 cases per 100,000 population, whereas the average for the continental United States was 81.24 cases. It ranks third in the number of cases of contagious or potentially contagious cases (primary, secondary and early latent) of syphilis reported per 100,000 population. Arizona reported a 47.63 case rate of contagious syphilis, while the average for the continental United States was 15.96. Arizona ranks 11th among the states and the District of Columbia in the number of cases of gonorrhea reported per 100,000 population, reporting 200.58 cases to 100,000 population compared to 129.75 for the continental United States.(1) On the basis of these figures, Arizona must be considered a high prevalence state. The question now arises, why is Arizona a high prevalence state? Veneral disease thrives among groups that are depressed economically and educattionally. In Arizona we have several such groups.

There are approximately 80,000 Indians in Arizona, and in spite of some notable gains in the last few years, this group still is the major focus of syphilitic infection.(2) We have migrant workers in this state. Approximately 60,000 enter the state each year. Repeated selective blood-testing has shown that about 8 per cent are infected with syphilis.(3) Contact investigation has shown that this group, too, is a major focus of infection. Then there are citizens of our own state living in the slums and sub-standard areas of our cities and towns. This group is depressed economically and educationally and is composed of various racial elements, white, Spanish American, and Negroes. Selective blood-testing has shown that these groups constitute a serious problem.(3)

Border, and Other Problems

Then there is the border problem. There are approximately 850 registered prostitutes in the Mexican cities and towns along the border, and an equal number of semi-professionals. There have been notable gains in keeping this group free from infection in the past few years, but it is still one of the major sources of venereal infection in Arizona.

What do these facts mean to the private physician in Arizona? If his practice includes any of the socio-economic groups named, he will see and treat a lot of venereal disease. The fact that these groups remain foci of infection, means that epidemics of a greater or lesser degree can explode from time to time into the rest of the population. This means that any physician, particularly the general practitioner, may be called upon to diagnose and treat venereal diseases. Another fact that heightens this possibility is that many college and high school boys from the higher economic strata visit regularly the houses of prostitution in Nogales, and elsewhere along the border.

The above facts help to define the problem generally. What are the specific problems of the physicians who treat venereal disease?

Let us first discuss diagnosis: The problems involved in the diagnosis of syphilis are many and varied. Some of these problems are peculiar to Arizona, or at least to the Southwest. The busy physician is often tempted to take as many short-cuts as possible. All too often, a diagnosis is made on the basis of one blood test. This temptation is made stronger by the mobile type of patient we often see. They are here today and gone tomorrow. Two visits to the physician's office by this type of patient is very often the maximum that can be expected. The physician is then faced with the dilemma as to whether or not it is better to treat the patient with a maximum dose of an antibiotic and let him go, or to adhere to good medical practice and definitely establish the diagnosis by a series of blood tests and other diagnostic procedures. Certainly, the latter procedure should be adopted for permanent residents of the state.

The problem of obtaining a medical history from each suspected case of syphilis is often complicated. The language barrier presented by Spanish speaking and Indian patients often makes this difficult. Because of the time-consuming nature of this procedure, it is very often not done, or incompletely done by the busy physician.

It is a well-known axiom in venereal disease control that all genital lesions should be examined and the serum from these lesions examined under the dark-field microscope for the *Treponema pallidum*. This is not done routinely by most physicians in Arizona. Few physicians' offices are equipped with a dark-field microscope, and in the outlying areas of the state there are no laboratories available where this can be done. We should return to the use of the dark-field microscope in the fight against syphillis. Steps should be taken to make this service readily available to all physicians in the state.

What is the status of the spinal fluid test and all the problems that go with it? Has the successful use of antibiotics obviated the rule that every case of syphilis should be given this test? The age-old problem of reactions to this test, and the patient fear of the test are still with us.

Increasing Problems

The biologic false positive patient is becoming more of a problem in Arizona. Physicians are seeing more and more patients whose only symptom of syphilis is a low titer reactive or weakly reactive blood test. How many physicians know that the public health laboratory at Chamblee, Ga., has made available the treponema pallida immobilization test to private physicians, when this test is submitted through the state health department? A specific antigen test for questionable bloods would be of great value to the physicians of the state, if it were readily available.

Non-specific urethritis is becoming more of a problem. The hot summer weather and the tight clothing worn by the males in Arizona make the male urethera an ideal spot to incubate the organisms that cause this disease. This disease often appears as a pencillin resistent strain of gonorrhea. Only laboratory procedures can rule it out, and further long-drawn out laboratory work is necessary to determine the offending organism.

The epidemiology necessary to control venereal disease is neglected by the practicing physician. There are some very good reasons for this. First, it is time consuming; and secondly, the private physician is not sure how far he can go legally and ethically in this activity. The physician can interview the patient for sexual contacts both familial and otherwise, but he is stymied in getting these contacts in for diagnosis and treatment. A closer liaison between the private physician and the health department should be maintained in order to make this control measure more effective.

These are some of the problems encountered by the private physician in Arizona. There are others. It is time we re-examined our venereal disease control activities. If these diseases are ever going to be brought under control, the private physicians must become aware of the problem and work in harmony with other agencies who are interested in the problem.

REFERENCES

1. VD Statistical Letters, U.S. Public Health Service, Department of Health Education and Welfare, 1949-1948.
2. VD Fact Sheet, 1957, U.S. Public Health Service, Department of Health Education and Welfare.
3. Unpublished reports, Arizona State Department of Health.
4. Paul L. Singer, M.D., President Maricopa County Medical Society.
5. A. B. Pasternack, M. D., Venereal Disease Clinician, Pima County Health Department.

DIAGNOSIS AND TREATMENT OF SYPHILIS

by
Evan W. Thomas, M.D.*
Albany, N. Y.

SYPHILIS is a complex disease, capable of a great variety of clinical manifestations. Fortunately, its diagnosis does not depend on our understanding the mechanisms underlying the many phenomena that may be associated with the disease. Nevertheless, it is well to keep in mind some of the fundamentals that are known about its immunology and pathology.

Early and late syphilis represent almost two distinct diseases. The early acute lesions are non-destructive and self-limited, healing spontaneously within days or at most, months. The early lesions are highly infectious because of the large number of treponemes found in them. The late lesions, when they occur, are chronic, destructive and relatively non-infectious. Thus, late syphilis is characterized by a markedly altered reactivity of body tissues to the *T. pallidum* from the early stage, and by obscure mechanisms which keep demonstrable treponemes in remarkably small numbers, except in cases of active general paresis where abundant organisms may be found in the cerebral cortex.

Cure of early syphilis can be followed by reinfection with the development of new early lesions, and inadequate treatment of the early stage may be followed by a relapse of early lesions. However, once an individual has entered the late chronic stage, the tissues, as a rule, have become permanently refractory to early lesions. Relapse or reinfection following treatment of the late stage is rarely associated with the development of early lesions. Furthermore, the late stage is usually associated with much greater resistance to reinfection, following cure, than is the early stage. This has been proved by experimental syphilis in rabbits and by a recent study of inoculation syphilis in human volunteers in Sing Sing Prison in New York State. The latter experiment showed that reinfection following probable cure of late syphilis is possible in some cases, but it is usually determined only by marked, sustained rises in the titers of serologic tests and not by demonstrable lesions. In all probability, reinfection following cure of late syphilis rarely occurs when patients are exposed to the relatively few treponemes encountered in naturally-acquired infections.

Another significant difference between early and late syphilis is the response of serologic tests for syphilis (STS) following treatment. These tests tend to become negative or to fall to very low titers within a year after successful treatment of early syphilis, but they usually remain positive for years following good treatment of the late stage, regardless of the kind, duration, and amount of therapy.

Diagnosis of Early Syphilis

In an unknown number of cases, syphilis may be acquired in the absence of demonstrable early lesions, or lesions may be so faint as to go unnoticed. However, the diagnosis of primary and secondary syphilis depends on lesions that are demonstrable.

Primary stage (chancre at site or sites of infection. Chancres are usually single but they may be multiple). Diagnosed by:

1. Finding the *Treponema pallidum* in serum from the chancre by dark-field microscope.

2. Serologic tests for syphilis (STS). Tests may be negative early. In the presence of a suspicious early lesion, STS should be repeated frequently for at least two or three weeks. When the STS begin to be positive, the titers of quantitative tests rise rapidly within a few days. Syphilis should be ruled out in the presence of any genital lesions.

3. History of exposure.

Secondary stage (initial reaction of tissues to the *T. pallidum* carried to the tissues by blood and lymphatics). Diagnosed by:

1. Dark-field microscopic examination of serum from lesions.

2. Positive STS. Sero-negative secondary syphilis, if it occurs at all, is so rare as to be negligible. The titers of quantitative tests are usually high, but individuals vary greatly in the amount of reagin formed. In the absence of demonstrable lesions, secondary syphilis should not be diagnosed but secondary lesions may be scanty and faint as well as profuse and obvious. In the absence of positive dark field examinations, a diagnosis of secondary syphilis should be made

*Consultant in venereal diseases, New York State Department of Health; Emeritus Professor of Clinical Medicine (Syphilology), New York University, College of Medicine; Formerly. Director of Syphilis Service at the Bellevue Hospital in New York City.

with caution, if the STS titers are positive in dilutions of less than 1 to 4.

Early latent (asymptomatic) stage (less than two years' duration). Authorities differ over the definition of early latent syphilis. For epidemiologic purposes some make it of less than one year duration, others of less than two years and still others of less than four years. It is diagnosed by:

1. Positive STS. As a rule, the earlier the infection, the higher the titers.

2. History. Without an accurate history of previous STS or of possible exposure to infection, the duration of the infection is at best a guess. Relatively high STS titers in young people, especially teenagers, suggest a diagnosis of early latent syphilis. The following information should be sought from every patient suspected of having syphilis, regardless of the stage:

a. History of genital lesions, or of skin and mucous membrane lesions.

b. History of previous STS – dates, where taken and results of reactions.

c. History of possible previous treatment for syphilis. In many cases it is wise not to mention syphilis in questioning patients, but to ask about tests for "bad blood" and "needle treatments" or "hip shots" (how many and how frequent).

Treatment of Early Syphilis

The following schedules of treatment are minimal, but they have proved effective for routine use:

1. Benzathine penicillin G – 2,400,000 units given in a single treatment by injections of 1,200,000 units in each hip.

2. Procaine penicillin in oil and aluminum monostearate (PAM) – 4,800,000 units given by individual injections of 1,200,000 units every two to five days.

Characteristics of Late Lesions

As is well known, some 60 to 70 per cent of syphilitics never develop demonstrable late lesions, but there is some evidence that even asymptomatic (latent) syphilis shortens life expectancy. When demonstrable, late lesions occur, they are of two general types: (1.) Chronic diffuse inflammations or degenerative lesions, and (2.) Gummatous reactions.

Chronic Diffuse Inflammations and Degenerative Lesions

These lesions are found chiefly in the cardiovascular and central nervous system tissues. They apparently start early in the chronic stage of the disease or not at all, but they rarely produce significant signs and symptoms for at least eight or 10 years. That the inflammations start early in the chronic stage is proved by the finding of syphilitic aortitis by microscopic inspection of tissue sections of the aorta within three or four years after infection, and by the well-accepted rule that, if a spinal fluid examination is negative for syphilis four years after infection, neurosyphilis will not subsequently develop. Asymptomatic neurosyphilis can be diagnosed at any time by spinal fluid examinations, but aortitis is rarely diagnosed during life, even by X-ray examinations, within 10 or more years after infection.

Gummatous Reaction

This type of lesion may occur in any tissue other than the intestines and female reproductive organs at any time during the late stage, even 30 or more years after infection. It has an explosive onset with relatively rapid development of signs and symptoms. The reactions are obviously allergic, due to contact of sensitized tissues with the *T. pallidum*. How and why some tissues develop this particular type of sensitivity is obscure. Once the sensitivity has developed, it apparently remains indefinitely.

Problem of Biologic False Positive Serologic Tests for Syphilis

The diagnosis of syphilis depends to a great extent on serologic tests. Standard STS, whether complement fixation or flocculation, are made with lipoidal antigens that are not absolutely specific. The problem of biologic false positive tests (BFPs) has received much attention in recent years. It has been claimed that among individuals in the upper economic groups, over 40 per cent of positive STS have proved to be BFPs. Findings such as these are due to the selection of cases where histories have created doubt as to the possibility of syphilis. What they actually indicate is that when a physician is in doubt as to the presence of syphilis because of negative histories, he has approximately a 50-50 chance of being right in his guess as to whether or not the positive STS represent syphilis.

Differentiation between true and false posi-

tive STS is made by means of specific tests such as the treponemal immobilizing (TPI) test and the Reiter protein complement fixation test.

If a physician is unable to obtain one of the more specific tests for syphilis, he must rely on the tests now in common use. If these tests are repeatedly positive, it is better to make a tentative diagnosis of syphilis and treat a previously untreated patient than to guess that the test is actually a BFP. Exceptions to this rule may be advisable when the physician is certain that exposure to syphilis has not occurred, but such exceptions are not common. It must be remembered, however, that this rule applies only to previously untreated patients. There is no value in retreating patients previously treated for late syphilis for the sole purpose of obtaining negative STS. Such retreatment is futile and it misleads the patient who is unnecessarily worried over the persistence of the positive test.

Diagnosis of Late Latent Syphilis

By definition, latent syphilis is an asymptomatic infection diagnosed solely by means of serologic tests for syphilis and by history. For an accurate diagnosis, asymptomatic neurosyphilis should be ruled out by spinal fluid examination and cardiovascular syphilis by X-ray.

A careful history of previous STS, previous treatment with antibiotics and possible exposure to syphilis as well as knowledge of the STS of the spouse (in the case of married patients) are essential in diagnosing latent syphilis. The titers of quantitative STS in late latent syphilis are usually low.

Treatment of Late Latent Syphilis

When asymptomatic neurosyphilis and cardiovascular syphilis have been ruled out, a single treatment with 2,400,000 units of benzathine penicillin (Bicillin) probably provides satisfactory therapy of latent syphilis. This treatment can be given by injections of 1,200,000 units in each buttock. No data on the effectiveness of such minimal therapy are available, but there is no reason to believe that late latent syphilis requires more therapy than does secondary syphilis, and there is good evidence that the single treatment with benzathine penicillin has been as effective for secondary syphilis as have 4,800,000 units or more of procaine penicillin in oil and aluminum monostearate (PAM) given in divided doses.

When it is impossible or impractical to rule out asymptomatic neurosyphilis by spinal fluid examination, and cardiovascular involvement by X-ray, it is advisable to treat asymptomatic late sphilis with at least four injections of 1,200,000 units of PAM, individual injections being given two or three times a week. This therapy should be adequate for asymptomatic neurosyphilis, if present.

Diagnosis of Neurosyphilis

Spinal fluid examinations are essential for an accurate diagnosis of neurosyphilis. Even symptomatic tabes dorsalis or general paresis should not be diagnosed without a spinal fluid examination, which is the best guide to the activity of a syphilitic process in the central nervous system.

A positive specific test for syphilis of the spinal fluid (Wassermann, etc.) indicates a past or present infection of the central nervous system, but it tells us very little about the activity of the disease. Activity is indicated by increased cell counts (more than four cells per mm. of fluid) and oftentimes by increased total protein in association with positive specific tests of the spinal fluid. Colloidal tests of spinal fluid, when made accurately and consistently, have some value in determining parenchymatous damage. However, abnormal colloidal curves give little or no reliable information as to activity and the tests are not as easily interpreted or as reliable as might be assumed from textbook descriptions.

The important tests for determining the activity of neurosyphilis are cell counts and total protein determinations. Unless these tests are made accurately, there is now little point in burdening patients with a lumbar tap merely to find out whether or not the fluid gives a positive specific test for syphilis, because the latter test alone is a poor guide in evaluating therapy. To evaluate therapy, spinal fluid examinations should be made at six-month intervals. Cell counts should be normal within six months after successful treatment, and they should remain normal. High total protein determinations should show some decline within six months, but the tests may not be within normal limits for a year or more. Relapse is indicated by increased cells and often by an increase of total protein and of quantitative specific tests of the spinal fluid.

Since it is often difficult to persuade patients to have repeated spinal fluid examinations, and since the reports of cell counts and total protein determinations are frequently unreliable, unless

done by special technicians, I no longer believe that spinal fluid examinations are as essential in the management of syphilis as during the pre-penicillin era. This is true because available data indicate that all types of neurosyphilis can be permanently arrested in over 90 per cent of cases by good penicillin therapy. This was by no means true of metal therapy which failed to permanently arrest neurosyphilis in at least 50 per cent of cases in my experience. In evaluating therapy of neurosyphilis, it must always be remembered that no treatment designed to destroy treponemes can restore normal function to important tissues that have been irreparably damaged.

Treatment of Neurosyphilis

Neurosyphilis should be treated with no less than 4,800,000 units of PAM and preferably with from 6 to 9 million units in very active cases. Individual injections of 1,200,000 units can be given two or three times a week until the total dose is completed. No data are available on the use of benzathine penicillin for neurosyphilis, but it is probable that two or three treatments with 2,400,000 units, with no more than a week intervening between treatments, would be satisfactory.

Diagnosis of Cardiovascular Syphilis

Cardiovascular syphilis has been classified into: Simple aortitis, aortitis with ostial stenosis, aneurysm, and aortic insufficiency. Aortitis is best diagnosed by fluoroscopy or teleroentgenograms. A widened aortic shadow, especially of the ascending portion, suggests syphilitic aortitis in an infected patient, but it does not always assure the diagnosis. Ostial stenosis can rarely be diagnosed accurately during life, but it can be suspected in some cases. Some aneurysms give physical signs, but the diagnosis is made best by X-ray. Aortic insufficiency can be diagnosed by the presence of a diastolic murmur at the base of the heart, high pulse pressure and water hammer pulse. In my experience, untreated cardiovascular syphilis is rarely associated with negative STS.

Treatment of Cardiovascular Syphilis

Cardiovascular syphilis can be treated the same as neurosyphilis. Many authorities advise from 6 to 10 million units rather than lower total doses. Treatment can be started with injections of 1,200,000 units of PAM without fear of Herxheimer reactions.

Diagnosis of Gummatous Reactions

It is beyond the scope of this paper to describe all of the various types of benign tertiary reactions observed in late syphilis. Most of them are gummatous reactions, and they are usually associated with very high STS titers. In some cases the best means of establishing the diagnosis is to note the response to therapy.

Treatment of Gummatous Reactions

This is the same as for neurosyphilis. The response to therapy of most benign tertiary syphilific lesions is dramatic, but healing always occurs with scar tissue.

Substitutes for Penicillin in Penicillin-Sensitive Cases

Many patients who give a history of urticarial reactions to penicillin become desensitized rather rapidly, and they tolerate subsequent penicillin therapy. In cases where the physician is convinced that penicillin cannot be used, syphilis should be treated with other antibiotics rather than with bismuth or arsenicals.

Oxytetracycline (terramycin) and chlortetracycline (aureomycin) have been used successfully to treat late syphilis, including neurosyphilis. These antibiotics can be given in doses of 0.75 gm. every six hours for 10 days for late latent syphilis, and for 15 days in cases of neurosyphilis, cardiovascular syphilis, and other cases of symptomatic syphilis. No good data are available on the use of erythromycin (Ilotycin) but Turner, et al., have reported that the *T. pallidum* is more sensitive to erythromycin and carbomycin (Magnamycin) than to any of the other antibiotics except penicillin. The recommended dosage is 0.5 gm. four times daily for 8 to 10 days in early and latent cases, and for 12 to 15 days in late symptomatic cases.

Evaluation of Treatment

Following therapy of primary and secondary syphilis, sero-negativity is usually obtained within one year. However, some 20 per cent of patients treated for secondary syphilis may have positive STS in low titers for more than one year. Retreatment is not advised unless the STS show marked increases from previous levels (sero-relapses).

Patients treated for late syphilis usually continue to be sero-positive for years after treatment. No patient should be retreated solely because of positive STS unless there is evidence of marked increases in titers from previous levels.

Therapy of neurosyphilis is best evaluated by serial spinal fluid examinations but these examinations are of little use unless careful cell counts and total protein determinations are made. Cell counts should be normal six months after successful therapy, and there should be a decline in abnormally high total protein.

THE EPIDEMIOLOGIC CHAIN

Robert Lugar*
Los Angeles, Calif.

IN MARCH 1958, a private physician referred a male patient with secondary syphilis to the Los Angeles City Health Department for the sole purpose of a contact interview. The resultant interview consumed approximately 35 minutes and yielded eight female contacts. Seven of the eight lived within the city and were brought to examination within three days. Two of the females were found to have infectious syphilis and were placed under treatment. The eighth contact in this epidemiologic chain was located in Wisconsin, diagnosed secondary syphilis, and placed under treatment.

The contacts obtained from the two local females, who were infected, resulted in further cases of syphilis brought to treatment. To date this one outbreak has produced eight cases of primary and secondary and four cases of early latent syphilis.

This illustration of epidemiologic success was made possible through the interest and concern of the private physician together with the interviewing investigative resources of the health department.

A co-ordination of the health department and private physician's interests in the individual and the community brings beneficial results. Morbidity reporting is one of the available methods geared to bring about this co-ordination. Considerable progress has been made in reporting of communicable diseases. In our own Los Angeles area when a physician reports a case of tuberculosis, a procedure evolves which demonstrates the co-operative, beneficial aspects of the program. With the physician's approval, a public health nurse visits the case immediately. All of the essential arrangements are made to assist the patient and the family. The patient is interviewed in an attempt to determine the names of those who may have been exposed to the disease so that they may secure medical supervision. With the accent on case finding, the same goal can be achieved in the field of venereal disease. Epidemiologic measures are necessary in order to eliminate the reservoirs of infection. Private physicians recognize this but, because the contact interview is time-consuming and because the investigative process often involves work in many different geographical areas, they find it impossible to devote the attention they would desire to give to epidemiology. This lost opportunity is considerable unless they have recourse to the services of the health department. The service offered by the health department to the physician is initiated in various ways. On some occasions, the physician selects patients with an infectious venereal disease, to be interviewed by a trained public health interviewer. Following notification, and to suit the convenience of the patient, the interviewer arranges for the time and place. In some areas physicians refer their patient initially for diagnostic service and interviewing if necessary. Thus the epidemiologic process begins while the patient is returning to his physician for treatment. Whatever plan of action develops will depend upon the physician's request in each case.

The Interview

The contact interview with a private physician's patient is a continuation of the high professional standards which surrounds the diagnostic and treatment procedure. It may be described as a serious conversation between two persons for a definite purpose, the obtaining of all sex contacts, scientifically in line with the duration of the infection. It is not altogether a one way street. Wherever the need exists, information on such matters as education, the importance of following his physician's advice, especially relating to post treatment follow-up, is supplied him.

The confidentiality of the interview is stressed whenever the need arises. The patient understands that the information he offers the interviewer will in no way be connected with him.

*Mr. Robert Lugar is health program representative, City of Los Angeles Health Department.

In consideration of certain reasonable reluctance on the part of the patient to divulge intimate sexual contacts, the public health department has seen fit to utilize the services of personnel who have received extensive specialized training. The skillful handling of the interview situation has brought remarkable fruit to bear, while at the same time the dignity of the patient has not been compromised. In many areas the interviewer and investigator are one and the same. However, where a division of duty exists, where the investigator was not the interviewer, the handling of contacts is carried out with the same consideration and finesse. When reached, the contacts are encouraged to visit their private physician for medical supervision. In such an instance, the doctor is notified of the impending visit along with whatever pertinent information is necessary. The service of the health department need not end here. With the finding and referral of another infected contact, the cycle continues. With such a co-ordinated program, community conditions, facilitating the spread and acquisition of venereal disease, would be controlled. It can only be through this type of co-operative effort that complete measures will be achieved.

UNITED FRONT IN VD CONTROL

William J. Brown, M.D., M.P.H.*
Atlanta, Ga.

ODDLY enough, I am going to begin my remarks to you not with a reference to syphilis, but to cancer. I would like to draw a parallel between an early cancer of a familiar type and the problem we face in venereal disease control today.

As you know, given a cancer of a type which is known to metastasize, a surgeon would not think of excising merely the primary site and stopping. Automatically he would trace the metastasis and take precautionary measures to trim or treat every possibly involved area and organ to the last lymph node.

I think we can all agree that if he does this, he is a good surgeon. If he fails to find and treat every trace, he is a less skillful surgeon.

Now, progress against syphilis in the United States during the past two decades is amply evident in long-range mortality and disability figures. I shall not cite comparisons except to say that syphilis mortality rate in this country is one-fifth of what it was 20 years ago, as are hospitalizations for syphilitic psychoses.

Reported cases of infectious syphilis also declined as significantly from the 1947 peak through 1954. However, since 1954, reported early syphilis has not continued its decline. Nor is there any indication that it has declined in fact. Furthermore, studies have shown that in most areas, reported syphilis represents less than half of that which is treated.

Oddly enough, reported syphilis halted its decline at a time when public health control efforts were being maintained at levels which in previous years were accompanied by significant declines. Why, then, this change of trend?

First, lest you think that syphilis had already declined to a minimum with which we could live comfortably, let me cite a few round figures representing the annual cost of syphilis to you, me, and all the taxpayers of this country.

For example:

Deaths known due to syphilis number 4,000 a year.

Maintenance of the syphilitic blind costs $12 million a year.

Hospitalization of the 30,000 syphilitic insane costs $48 million year.

And loss of income by men with advanced syphilis is conservatively estimated at $100 million a year.

Hundreds of thousands of persons in this country need treatment for syphilis now. And if they are not found and treated:

An additional 1 in 200 will become blind.

An additional 1 in 50 will become insane.

An additional 1 in 25 will become crippled or incapacitated to some extent.

And an additional 1 in 15 will become a syphilitic heart victim.

I submit that *these* are *not* minimums with which we can live comfortably.

By the way, I have not even mentioned gonorrhea, but we are just as far behind in the control of gonorrhea as we are with syphilis. Perhaps farther.

Efforts Not Enough

Much has been done to control these diseases. Great efforts have been expended by the legions of persons who have devoted their careers to the control of venereal disease — efforts which frequently have not fallen short of heroic.

But these efforts are not enough. Syphilis and gonorrhea are malignancies in the body politic. Like metastatic cancers, their etiology is subtle, their progress quiet but sure, and their effects deadly.

To treat a single patient and ignore his contacts is to trim out the original site of a tumor and bid the patient Godspeed. Just as surely as sin, syphilis will travel — has traveled, and will continue to travel its geometric paths to every corner of the state, the nation, and the world, without regard for any boundary.

I feel sure that most of you are familiar with the process known as "contact tracing." As patients are diagnosed, they are interviewed and asked to name those persons to whom they were exposed sexually since the beginning of the incubation period, up to the time when treatment renders them non-infectious. These contacts are then located, examined, and if necessary, treated, all in the strictest confidence.

In this way 160,000, or about half, of the known venereally infected persons are interviewed annually in this country, and through

*Chief of Venereal Disease Branch, Communicable Disease Center, U.S. Public Health Service, Atlanta, Ga.

them an additional 150,000 sex contacts are located, examined, and if necessary, treated.

It has now been shown that in addition to sex contacts, the group of convivial associates of infected persons also includes many infected and infectious persons.

Recently, venereal disease specialists have begun to trace the diseases through these chains of association as well as through the chains of sex contacts, and in this way have almost doubled the number of infectious syphilis cases which could be traced from one known infected person.

Now this system of epidemiology is not perfect, gentlemen, and I will be the first to admit it. As with medicine, and every other endeavor in life, perfection is more sought after than achieved. This, by no stretch of the imagination, is meant to disparage the venereal disease workers of this country. By and large, (and I speak humbly from 20 years' experience in the field of medicine) I have never seen a group of persons as thoroughly competent and totally dedicated to the pursuit of an occupation as are those whose duty it is, day in and day out, to cope with these diseases. They have demonstrated the efficacy of their skills beyond the shadow of a doubt. And I am sure I speak for these workers when I say that they stand ready to join hands with private medicine in a partnership to fight venereal disease.

I believe, as did Dr. Thomas Parran when he wrote that now-famous book, "Shadow on the Land," that to control syphilis:

"*Every* early case must be located, reported, its source ascertained, and *all* contacts followed up to find possible infection. Enough money, drugs, and doctors must be secured to make treatment possible in *all* cases. Both public health agencies and private physicians throughout the country must be aligned to form a *united front*, and re-educated to use scientific modern methods in their joint fight against syphilis."

Importance of Interviews

Studies have shown that private physicians are reporting almost half of all the infectious syphilis reported. But most of these cases are not being interviewed for contacts. During the five-year period in which practically no progress has been made against syphilis, studies show that of all the reported *lesion* patients of private physicians only 16.6 per cent were interviewed by a trained venereal disease epidemiologist. At the same time, 86.3 per cent of public clinic patients of the same category were so interviewed.

Applying national indexes, we find that through failure to interview known reported cases of lesion syphilis during this period, an unknown 3,000 additional primary and secondary syphilis cases were free by default to spread their diseases at will.

On the brighter side, there are many examples of excellent co-operation of health departments and private physicians in scattered areas of the nation. Many a case of lesion syphilis diagnosed, treated, and reported by a private practitioner has been instrumental in locating and bringing to treatment a host of other infected persons. But this *should* be true in many hundreds if not thousands of cases if we would succeed in controlling syphilis.

I cannot believe that there is any real reason why public health and private medicine has not to date worked successfully together to stamp out venereal disease entirely from within our borders and to hold it to the barest incidence.

Public health people, in working with patients of private physicians, are certainly aware of the private doctor's responsibility to his patients. In fact, those public health people who have been engaged in venereal disease control have developed to a fine art the whole realm of doctor-patient relationship, and have gone to extreme lengths to protect patient confidence. This has been drilled into them from their first day on the job. Moreover, their approach to any and every person involved in a chain of infection is of necessity tempered with caution, courtesy, and compassion.

They are people dedicated to a singular theme – the ultimate eradication of these deadly and crippling diseases. Given a chance, they will

work hand in hand with and for the medical profession, saving busy doctors many long, tedious, and laborious hours of difficult but necessary work.

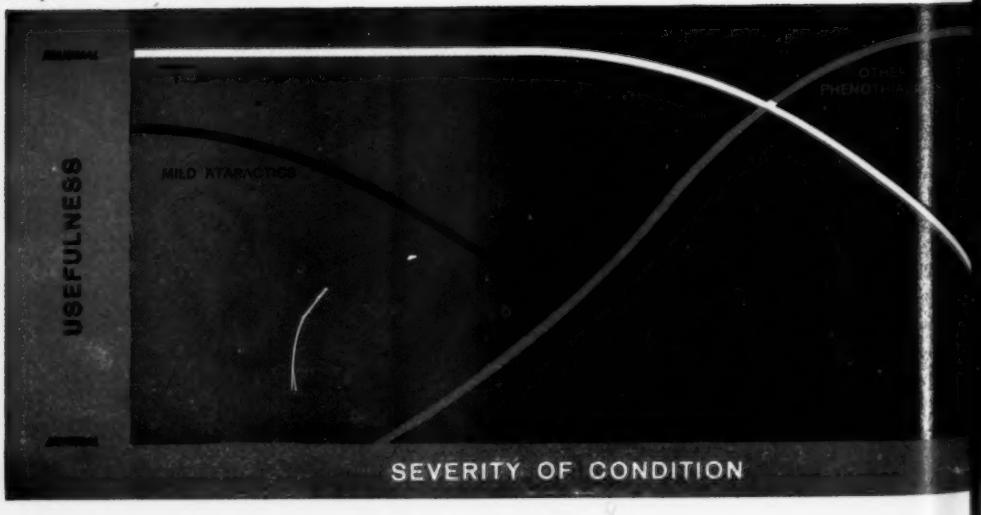
Furthermore, they are equipped to handle an aspect of VD epidemiology which obviously is beyond the resources of the individual physician – and that is geography. It is trite but true that Americans are a people on the move. Probably the so-called syphilis prone segments of our society are the most mobile of all – and they carry their syphilis with them. Last year, health departments reported that 14 per cent of all VD contacts named lived in a different state from the patient. Unmistakably, this mobility makes the job of contact tracing more difficult, but it is not impossible. Public health facilities in this country have a well developed and efficient method of transmitting VD epidemiologic reports from one state to another. Incidentally, confidentiality is built into this system since the name of the patient never appears on these reports.

The VD workers of this country are prepared painstakingly, with the precision of good and skillful surgeons, to trace and bring to treatment each dangerous and death-dealing infiltration of infection into the body of society.

In closing, I would urge both public health personnel and private physicians to explore every avenue of co-operation. And not *just* to explore, but to *act* together as a united front in venereal disease control.

new... highly effective tranquilizer

Comparison of TENTONE usefulness



...for extended office practice use

Tentone

Methoxypromazine Maleate

LEDERLE

NEW PHENOTHIAZINE COMPOUND FOR THE LOWER AND MIDDLE RANGE OF DISORDERS

Positive, rapid calming effect in mild and moderate cases. Striking freedom from organic toxicity, intolerance, or sensitivity reaction—particularly at low dosage. Greater freedom from induced depression or drug habituation. May be useful, as with other tranquilizers, to potentiate action of analgesics, sedatives, narcotics. Facilitates management of surgical, obstetric, and other hospitalized patients. Indicated when more than a mild sedative effect is desired...and less than psychosis is involved. Dosage range: *In mild to moderate cases:* from 30 to 100 mg. daily. *In moderate to severe cases:* from 75 to 300 mg. daily.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Supplied

10 mg. tablets

25 mg. tablets

50 mg. tablets

Editorial Section

ARIZONA MEDICINE

Journal of

The ARIZONA MEDICAL ASSOCIATION, INC.

VOL. 16 JUNE, 1959 NO. 6

Darwin W. Neubauer, M.D. ..... Editor
Louis G. Jekel, M.D. ..... Assistant Editor

EDITORIAL BOARD

Andre J. Bruwer, M.D.
Richard L. Dexter, M.D.
Juan Fonseca, M.D.
Clarence Robbins, M.D.
Leslie Smith, M.D.
Elmer Yeoman, M.D.

ASSOCIATE EDITORS

Charles W. Elkins, M.D. ..... Neurosurgery
Mrs. Juan Fonseca ..... Women's Auxiliary
Jesse D. Hamer, M.D. ... American Medical Ass'n. & Legislation
Walter T. Hileman, M.D. . House of Delegates and Council Action
John Kennedy, M.D. ..... Historical Section
Robert Lacock, M.D. ..... Ob-Gyn.
William B. McGrath, M.D. ..... Neuro-psychiatry
C. Thomas Reed, M.D. ..... Chest Surgery
Gerd Schloss, M.D. ..... Pathology
Paul L. Singer, M.D. ..... Genito-Urinary
L. D. Sprague, M.D. ..... Medical Economics
Alvin L. Swenson, M.D. ..... Orthopedics
Roger F. White, M.D. ..... Pediatrics

(The opinions expressed in the original contrfbutions do not necessarily express the opinion of the Editorial Board.)

FORMER EDITORS

Frank Milloy, M.D. ..... Jan. 1944-Oct. 1952
R. L. Foster, M.D. ..... Nov. 1952-April 1956

COMMITTEE ON PUBLISHING

Darwin W. Neubauer, M.D., Chairman ..... Tucson
R. Lee Foster, M.D. ..... Phoenix
Frederick W. Knight, M.D. ..... Safford
C. L. Robbins, M.D. ..... Tucson

ADVERTISING AND SUBSCRIPTION OFFICES
J. N. McMEEKIN, Publisher and Business Manager,
801 N. 1st Street, Phoenix, Arizona
Eastern Representative
A. J. JACKSON, President
State Journal Advertising Bureau
510 N. Dearborn St., Chicago 10, Illinois

CONTRIBUTORS

The Editor sincerely solicits contributions of scientific articles for publication in ARIZONA MEDICINE. All such contributions are greatly appreciated. All will be given equal consideration.

Certain general rules must be followed, however, and the Editor therefore respectfully submits the following suggestions to authors and contributors:

1. Follow the general rules of good English, especially with regard to construction, diction, spelling, and punctuation.
2. Be guided by the general rules of medical writing as followed by the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.
3. Be brief, even while being thorough and complete. Avoid unnecessary words. Try to limit the article to 1500 words.
4. Read and re-read the manuscript several times to correct it, especially for spelling and punctuation.
5. Manuscripts should be typewritten, double spaced, and the original and a carbon copy submitted.
6. Articles for publication should have been read before a controversial body, e.g., a hospital staff meeting, or a county medical society meeting.
7. Exclusive Publication—Articles are accepted for publication on condition that they are contributed solely to this Journal. Ordinarily contributors will be notifed within 60 days if a manuscript is accepted for publication. Every effort will be made to return unused manuscripts.
8. Illustrations — Ordinarily publication of 2 or 3 illustrations accompanying an article will be paid for by Arizona Medicine. Any number beyond this will have to be paid for by the author.
9. Reprints — Reprints must be paid for by the author at established standard rates.

The Editor is always ready, willing, and happy to help in any way possible.

(The Opinions expressed in original contributions do not necessarily express the opinion of the Editorial Board.)

ANNUAL MEETING ATTENDANCE

THE 1959 Annual Meeting is no longer merely a fair prospect but now a part of the history of the Association. While its memory is still unfaded, a commentary looking to the future may be profitable.

It can reasonably be maintained that never have we had a more distinguished and knowledgeable group of speakers. The day devoted to a panoramic view of modern medical education was vital for the future of the profession in Arizona. The panel that conducted this special symposium was truly eminent and widely informed. It is regrettable that more of our members were not present at the convention on this day and that many of those who were in Chandler were evidently unable to attend the sessions.

Three particular questions arise from the experience of the 1959 Meeting. First, why in the past three years has there been a decline in our total registration? It was 310 this year, as contrasted with an all time record of 366 in the same location in 1956. Second, why do the scientific papers attract only a limited audience? The maximum count in the hall was probably not over 85, and during one of the medical education conferences an actual tally showed 50 listeners, not all of them physicians. This was a discussion that was expected to entice almost every registrant. Third, why are the exhibit booths poorly visited? Some of the exhibitors realized so little traffic that they pulled off the floor 24 hours before the end of the meeting. Perhaps it is necessary to remark just once more that the commercial displays not only defray a large part of the convention expenses but also provide an opportunity for a preview of recent research by the staffs of the great pharmaceutical houses.

The Scientific Assembly Committee is charged with the immediate responsibility of beginning planning for the 1960 Annual Meeting. It hopes, of course, to prepare a prospectus that will impress the doctors of Arizona and will allure them in large numbers. The relatively meager attendance this year is puzzling, and in an attempt to ascertain its cause a question-

naire will shortly be mailed to each member. Inquiry will be directed to a statistical exploration of the general type of program desired, the topics believed to be of broadest interest, the most convenient scheduling and timing of individual presentations, the advantageous placing of exhibits, and the balance to be sought between scientific, social, cultural, and sporting observances. It is trusted that everyone will consider the questionnaire thoughtfully and answer it promptly.

The Association does have a goal for the 1960 convention. It hopes for 500 registrants and an attendance of 150 to 200 at all scientific sessions.

PROGRESSIVE ACTION*

RECENT action by Chicago Truck Drivers, Chauffeurs and Helpers Union may be the forerunner of a new trend in union health care plans.

The action by the union's trustees called for abandonment of two six-year-old closed panel clinics in favor of a new health plan which allows free choice of physicians and hospitals.

The new plan is in the process of being worked out by Edward Fenner, the union's director, and the Chicago Medical Society.

Fenner believes the so-called closed panel method of maintaining medical clinics is antiquated, that union members should have the right to choose their own physicians and hospitals, and that only in this way will members seek adequate treatment and, therefore, have the best possible medical care.

The Chicago union director hopes the United Mine Worker will go back to a plan giving all its members free choice of physician. And he believes auto workers and steel workers will make a "gross error" if they adopt closed panel systems.

Fenner is giving his members what they want — to go to their own doctors. And it is interesting to note that union members preferred "free choice" even though they must pay part of the cost of medical care under the new plan.

This decision on the part of union members backs up the national survey reported in The AMA News (Oct. 20, 1958) in which 76 per cent of the people said they believed the individual's right to choose the physician of his own choice is extremely important, even under economic pressure.

Eighty-eight per cent said they believed the continuity of the doctor-patient relationship is vital to good medical care.

Now, if other unions with closed panels will follow the action by the Chicago truck drivers, the long-standing controversy over the basic right of free choice will end. And the change would have a salutary effect on all such health care plans.

As we pointed out in these columns last October, the AMA has been deeply concerned about the future impact on the physician-patient relationship in plans in which the physician is not responsible directly to the patient.

Of course, in all such plans, physicians have responsibilities, too. If the basic freedom of free choice is to be preserved, physicians must give competent medical care, and must police their own ranks to eliminate professional incompetence and economic abuses.

The Chicago Medical Society is in the process of negotiating an arrangement with the Chicago truck drivers' union which will protect the interests of both the union members and the physicians. No fee schedule is contemplated, but "reasonable" charges will be assured by medical society surveillance.

These recent developments are highly encouraging. And the union leaders who have taken the forward steps toward the best possible medical aid for their members have displayed commendable zeal and wisdom. It is hoped that others will follow their lead.

*Reprinted from the AMA NEWS, April 6, 1959.

QUALITY MEDICAL CARE*

THERE are lessons to be learned from the rift between the medical staff and the meat cutters' union at the St. Louis Medical Institute.

When the chief of the medical staff charged interference by the union leader in "matters having to do with the quality of medical care," it was further evidence that it is the medical profession that is concerned with the quality of medical care for all patients.

And whenever there is interference by union officials or other non-medical lay administrators in strictly professional matters having to do with medical care and doctor-patient relationships, the end result can only be a deterioration in the quality of medical care.

That is one reason why some members of the

*Reprinted from the AMA NEWS, March 23, 1959.

medical profession look with suspicion upon such closed panel plans. Not that the St. Louis situation is repeated in all other such programs, but St. Louis is proof that it can happen.

The St. Louis and St. Louis County medical societies are not opposed to patients financing medical care individually or through third parties, but they are opposed to interference or dictation of medical decisions. This is as it should be.

When a plumber, carpenter, or coal miner interferes in a medical decision it is akin to an M.D. telling a steel worker how to shape an ingot.

LETTER TO THE EDITOR

Sir:

IT HAS come to my attention that physicians have been violating the law regarding the confidential nature of professional communications. This is more than an ethical question, because the statutory law of this state covers the subject, and although no physicians have been sued for damages, nor have there been any formal complaints of unprofessional conduct, so far as I know, there have nonetheless been situations from which such consequences could have resulted. As you will see from my observations below, there are many difficult cases, but it is my reaction that the physicians should approach the whole question with considerably more care and caution than seems to be the common practice, and that they should keep in mind the principles of the subject as a general frame of reference.

In the event an examination is made (when no litigation has been filed) at the request of an insurance company or someone other than the patient, it being assumed that the patient has consented to such examination and has authorized the release of information to such other party; the patient may also request that all such information be released to him, and it is entirely proper at this stage of the proceedings to furnish him a copy of any reports or statements made to the other party.

Arizona law provides that doctors shall report to the police or the sheriff's office any cases of gunshot wounds, stabbings, etc., that would indicate that a crime had been committed. This is a duty imposed upon physicians by law, and must be observed. Its observance however requires the exercise of considerable care, inasmuch as such reports should be based on objective evidence only, and not upon hearsay comments. I have actually had experience with a case in which neighbors told a physician a long story of crime in order to induce him to report it, although there was nothing to indicate that the injuries were not the result of perfectly innocent causes. In cases of that sort, a physician can only suggest that such people report the matter themselves. If the physician finds himself in doubt as to the matter, he should probably seek the advice of counsel, for he should not expose himself to the criticism of failing to report, nor on the other hand, of making baseless charges against people.

AN ATTORNEY

WIKLE'S

Specializing In

OFFICE SUPPLIES

22 East Monroe

ALpine 8-1581

Phoenix, Arizona

CORRECTION

The footnote appearing on page 363, May issue Vol. 16, No. 5 should have read "9th Annual Post Graduate Medical & Surgical Conference, Pioneer Memorial Hospital, Brawley, California."

Surgical Forum of Graduate Surgeons

1. SURGICAL CONSIDERATIONS OF DISEASES OF THE LIVER*

William A. Altmeier, M.D., Professor of Surgery, University of Cincinnati

THE inflammatory diseases of the liver are either viral or microbial in origin. The viral have no surgical treatment. The microbial may develop a liver abscess; these are usually multiple and usually in the right lobe of the liver. The patient has had a septicemia with localization of the organisms in the liver getting there through the hepatic artery. The various types of liver abscess are: (1) pyogenic, 20 per cent of which are streptococcal in origin, 17 per cent due to staphylococci, 31 per cent due to B coli. (2) amoebic abscesses. (3) from actinomycosis, and (4) from echinococcus. The fever may be remittent or intermittent, associated with chills, sweats. Pain, which most frequently is in the right upper quadrant, radiates to the right shoulder. Ninety per cent of the patients will show the above group of symptoms. Thirty per cent of the patients will have hepatomegaly, nausea, vomiting, jaundice, loss of weight and leukocytosis.

Complications include: (1) septicemia, (2) rupture into the peritoneal cavity, (3) rupture into the pleural cavity, (4) lung abscess.

Treatment consists of: (1) incision and drainage, (2) antibiotic therapy, at least two to three days before incision and drainage; (3) supportive therapy; (4) ligation of the portal vein is of no help. The mortality is 70 per cent; 40 per cent with surgery; 90-100 per cent without surgery.

Surgical operations in vogue for hemorrhage from cirrhosis of the liver, (1) is direct ligation of the varices with mediastinal packing; (2) the shunt operations; (3) ligation of the hepatic and splenic arteries; (4) the Phemister operation which is an esophago-gastrectomy; (5) resection of the lower esophagus and the upper stomach with interposition of the jejunum or right colon.

The results are poor from the trans-abdominal approach in ligation of the vessels at the cardiac end of the stomach. With hepatic and splenic artery ligation, one-third of the patients survive and return to work. If a shunt is to be done, using the vena cava is preferred, removing an ellipse from the vein. The splenorenal shunt has the advantage of removing the source of hypersplenism.

Tumors of the liver are:

(1) Metastatic. Questionably a lobectomy would be recommended, but none have been seen to do.

(2) Cancer of the extra hepatic ducts. Eighty-seven per cent are differentiated adenocarcinoma. Twelve per cent are undifferentiated adenocarcinoma; and 1 per cent a squamous cell carcinoma. Symptoms are very similar to that noted in interhepatic carcinoma.

(3) The interhepatic biliary carcinoma.

a. The cholangio-carcinoma and adenocarcinoma, both of which are highly malignant. The third interhepatic type of carcinoma is the sclerosing adenocarcinoma which grows slowly and results in death in only 5½ to 7 years after the diagnosis.

The symptoms from these tumors are insidious in onset. There is a progressive jaundice, mild epigastric pain, and late, a renal failure.

*Surgical Forum Of Graduate Surgeons, Los Angeles, Calif., March 1959.

2. ADENOMA AND CARCINOMA OF THE THYROID

Dr. George Crile Jr., M. D., Cleveland, O.

The various types of goiter are:

1. Diffuse. This is extremely rare. There is a diffuse hyperplasia. It is noted at times in infants and children, and in girls up to their teens. Some are due to diet, possibly due to an unusual intake of cobalt or soyabean milk. It disappears on the feeding of thyroid. The trouble seems to be with synthesis of the thyroid. This may go on for years, and with surgical removal it frequently will recur with each removal.

2. Nodular hyperplasia, which is very frequent. It occurs sporadically, basically on a familial basis. It is familial in more than 50 per cent of the cases. There is an enzymatic failure. Early in the disease, there is a hypothyroid state. The nodules develop either as a result of an excessive production of thyroid stimulating hormone (TSH) of the pituitary, or a peculiar sensitivity to TSH of the same cells.

3. The third type of a goiter is subacute thyroiditis. You have a hard tender mass, may not be big. It should not be confused with Reidel's struma. It is felt that the latter problem (Reidel's struma) disappeared with the disappearance of the endemic goiter. Subacute thydroiditis is a fibrositis of the entire neck, and one has not been seen for the past six to eight years.

Struma lympomatosa is an auto-immunity of the patient to his own production of thyroglobulin. Thyroglobulin reaches the circulation, a state that should not exist. The patient develops an immune reaction to it. Lymphocytes pour in. The antibody destroys the thyroglobulin. This diagnosis can be established by the uptake of radioactive iodine. Following this study if one gives TSH, if there is no greater uptake of the radioactive iodine after the administration of TSH, you are dealing with struma lymphomatosa. This problem is treated with dessicated thyroid.

Graves's disease. It is felt we know very little about the physiology of this problem, but it is believed that it is not related to an increased production of TSH.

Carcinoma of the thyroid. The pituitary stimulates the thyroid by the production of TSH. The administration of thyroid hormones stops the output of TSH. The administration of thiouracil leads to hyperplasia and to nodularity. In rats, a dependent cancer is noted following the administration of thiouracil. This disappears with a decreased production of the excessive TSH. This can be brought about by the administration of thyroid. On multiple transplants of this dependent cancer in rats, they are able to develop an autonomous cancer.

The incidence of adenoma of the thyroid and cancer of the thyroid. If this is considered on the basis of 1 million people and in the adult population, 6 per cent will develop palpable nodules. That is, 60,000 per 1 million. Of this million, 800,000 will have pathological nodules of the thyroid, and 30,000 will have pathological cancer, but the deaths per year from cancer of the thyroid are only six per million. Four of these are of such malignancy that they would die anyway. Therefore, it is believed that only one would be saved by the prophylactic removal of nodules of the thyroid.

Accuracy of diagnosis of cancer of the thyroid can be relatively good, if one considers 100 patients with cancer of the thyroid. Twenty will have undifferentiated carcinoma which is extremely malignant. Twenty will have a lesion of medium malignancy. These are clinically indistinguishable from the solitary firm tumor in the young, and they should be removed. Seventy of the patients will have papillary carcinoma. Forty of these 70 will have cervical nodes which are palpable. Of the remaining 30, it is felt that the nodule is of such consistency that one should recognize it. Therefore, it is a clinical impression that 85 per cent of the malignant cases should be suspected clinically. Suspect only 15 per cent, and you may miss your diagnosis.

It is not known if every nodule of the thyroid should be removed. Opinion seems to be adverse to this. Certainly solitary nodules in the teenage group should be removed.

Types of cancer:

1. Papillary cancer. At the Cleveland Clinic, a tumor is classified by the highest grade of malignancy shown anywhere in the tumor. In the pre-puberty group and after menopause, there is a greater number of these lesions that are malignant. From puberty to the period of menopause, it is rare for a patient to die from cancer of the thyroid.

If you remove the thyroid, or use radioactive iodine, you are very likely to stimulate any malignant tissue remaining.

Metatasis from cancer of the thyroid are frequently down the central compartment into the superior mediastinum. An area that can be obtained usually through neck dissection. Therefore, it is advised to go low in the neck, not specifically into the mediastinum, and use a low and high transverse neck incision rather than the classical incision for radical neck surgery. Three grains of thyroid per day may be used to encourage the regression of any tumor that might remain.

In a review of 107 cases, all of them operated upon four years or more ago, with an average period of nine years since surgery, the cases were divided into two groups, including 75 cases where the original operation was done at the Crile Clinic. Only one patient had trouble, and that was in a case where a needle biopsy was done and had a skin metastasis. This was prior to the realization of the protective effect of thyroid. There are no evidences of a neck recurrence in any of these cases. In the second group, those operated upon elsewhere, 30 per cent were lost due to recurrence.

In considering a total versus a subtotal thyroidectomy, and considering the 75 cases previously mentioned, no recurrence or evidence of a lesion in the opposite lobe in 85 per cent was found. In 15 per cent of the cases, totals were done only if there was an evidence of metastasis

to the opposite side.

Following surgery, thyroid was given routinely without recurrences. It is felt that radioactive iodine and external irradiation are extremely dangerous.

There is belief that we must differentiate the various types of cancer. The undifferentiated carcinoma no operation will help. In papillary carcinoma, in which the primary and any involved nodal groups are removed, thyroid hormone is given following surgery. Checking at surgery in these cases, particularly the central area and the superior mediastinal area.

3– ROUNDTABLE DISCUSSION CONSISTING OF THE PARTICIPANTS, DRS. ALTEMEIER, BEAN, CRILE, DENNIS AND RANDALL.

Dr. Altemeier: Discussed sclerosing adenocarcinoma as an interhepatic lesion. He finds it an extremely difficult diagnosis. In their cases, most were in the left hepatic ductal systems. To make a diagnosis, he feels one must get a representative biopsy and one should do a lobectomy if the lesion is localized to that lobe. If a specific diagnosis cannot be made, he would encourage a dilatation of the stricture evident in that biliary system, insert a tube, drain the area, take a cholangiogram and after the fixed tissues are available, perform surgery as indicated by the pathological report. He feels that this tumor is frequently well differentiated, slow growing and should be operable, and in a certain number of cases, curable.

Dr. Crile: In discussing this lesion, he felt that the carcinoma of the bile ducts, whether interhepatic or extrahepatic is an infiltrative lesion. All have a poor prognosis. There are few or no cures. It his his opinion that no jaundice develops until the right duct is also obstructed as well as the left. He tries only to get a catheter above the area of obstruction as a palliative measure. He believes that these lesions act very much as a sclerosing carcinoma of the stomach. Both Dr. Dennis and Dr. Crile would not encourage radical surgery on these patients.

The use of intervenous cholangiography has helped in the diagnosis of only one case.

Dr. Altemeier stated he had seen the development in 10 cases of jaundice where only the left hepatic duct had been obstructed.

Dr. Bean was presented with the question: "How can you keep from operating upon a patient with viral hepatitis?" The answer was simply, "Give up surgery." Obstructive jaundice will lead to hepatic cell damage. And conversely, viral hepatitis will give an interhepatic obstructive jaundice. Therefore, you have both parenchymal and obstructive jaundice in both of these cases. If the diagnosis cannot be established, he would encourage an operation, for he feels the prime failure has been in discouraging surgery in this group of patients rather than operating upon some where relief of the obstruction would be quite essential. *(An internist speaking)*

Dr. Dennis reported that Cecil Watson will do a cholecystostomy under local anesthesia, inserting a tube, decompressing the biliary tree for three days and then carry out a choledochogram. In this manner attempting to separate the case with hepatitis and the one with obstructive jaundice.

If in operation, a collapsed biliary system is found and an enlarged liver, Dr. Altemeier would do no drainage of the biliary tree. Dr. Randall would concur. Dr. Crile would attempt to drain off what bile could be drained off, feeling that the more toxic bile to the liver is that which has been reabsorbed from the gastrointestinal tract.

Accidental ligation of the hepatic artery was discussed by Dr. Altemeier. In the presence of cirrhosis, he feels that there is enough of a collateral circulation and if the patient is treated with penicillin and the tetracycline drugs most will recover. He does not know what is the development in the absence of cirrhosis. He has never seen an autopsy which resulted from a ligation of a hepatic artery and then the subsequent infarction of the liver. Dr. Randall reported two cases of total infarction due to hepatic artery ligation. Dr. Dennis reported four out of five died after ligation of the hepatic artery for bleeding esophageal varices. Dr. Altemeier could not concur in this statement, for he had 12 survive.

In discussing arterial aneurysms of the hepatic artery, Dr. Altemeier had had three cases. One had been ligated above and below the aneurysm and recovered. One had the artery ligated and died in liver insufficiency, but the patient had been in shock for eight hours prior to surgery being performed. He now would try to restore the artery, although he doubts that he is capable of doing it.

Dr. Crile would operate on the papillary carcinoma of the thyroid and upon the occasional carcinoma noted in children up to the age of 15. He does not recommend operation upon the anaplastic carcinoma which he feels includes 15 per cent to 20 per cent of the malignancies of the thyroid. He would irradiate these, and this is an unsatisfactory form of therapy. He would prove his diagnosis by a needle biopsy. The lymphomas of the thyroid he would irradiate and treat with thyroid. He feels that irradiation of the differentiated carcinoma or papillary carcinoma is dangerous procedure. In the anaplastic malignancy, he would not recommend and would be quite adverse to a radical procedure.

Dr. Randall had quite a different approach than Dr. Crile. He did concur that the anaplastic carcinoma presented a futile situation, that in the middle-age group and with a malignancy of the thyroid, anything you might do is likely to be attended by many years of survival. He would encourage actively treating the patient with thyroid. Of those with papillary carcinoma who will die from the disease, most of them do so within two to three years, and certainly within five years.

In questioning Dr. Crile about the nodular goiter, he would not operate upon them. He does not believe that 5 to 14 per cent will develop cancer. He puts all of these on thyroid, at least 1 grain for life. He has not seen anything grow in these cases except in some instances, cysts. Ten per cent will have a striking regression in the first three months and he checks them at the end of three months. During this first three months, he will usually put them on 3 grains of thyroid daily. If at the end of three months there is no regression, he puts them on a maintenance dose of 1 to 2 grains daily. The toxic, nodular goiter, he feels should be operated upon and obtains 100 per cent good results.

Dr. Crile treats Grave's disease in all cases with radioactive iodine. He does not do a subtotal thyroidectomy. Even if this toxic gland is noted in the 10-to-12-year-old group. This course they have followed for the past 12 to 13 years. He believes that this does not result in the total irradiation greater than the patient receives with obtaining a routine GI series. In polling the panel on this problem of treating Graves's disease, Dr. Altemeier recommended limiting the radioactive thyroid to patients more than 38 years of age. For, he feels that they have noted too many instances of cancer of the thyroid developed in patients who had previously been irradiated for an enlarged thymus. Dr. Bean uses radioactive iodine a little more freely, starting its use in the late 20s, but he does believe that the ill-effects that will be noted from irradiation of these patients will not be noted for 20 years or more after they have been irradiated. Dr. Randall will use radioactive iodine only if the patient is more than 40 years of age. Dr. Dennis agreed with the course followed by Dr. Altemeier. Dr. Crile stated that he would not knowingly treat with radioactive iodine, a pregnant female with a toxic thyroid. But, he has done it within the third trimester of pregnancy and without harm to the patient or child. Dr. Crile would do surgery as necessary for any patient developing malignancy following irradiation therapy.

Dr. Bean was questioned upon the use of tubes for the treatment of hemorrhage from esophageal varices. He feels that theoretically this procedure is good. If a tube is in for too long a period, or in a poor position, following removal of it there may be a recurrence of bleeding. He believes that a shunt will prolong life for the patient. This is an unproved statement. In a patient who continues to have ascites after the performance of a shunt operation, Dr. Bean would treat him with the removal of salt from the diet, the use of diuretics, including albumen, paracentesis, and if an aldosterone antagonist could be developed, it would be helpful. But in these cases, he feels we are in a position of defeat and should accept it as that.

Downtown Doctors Building

Will Pay For Itself — 10% Interest On Down Payment
Let Me Explain

L. L. STEWARD, Broker
AL 4-1636
1414 E. McDowell Rd.
Phoenix, Arizona

In smooth muscle spasm...

• controls *stress*

• relieves *distress*

Pro-Banthine® with Dartal®

Pro-Banthine—
unexcelled for relief of cholinergic spasm—
has been combined with
Dartal—
new, well-tolerated agent for stabilizing emotions—
to provide you with
Pro-Banthine with Dartal—
for more specific control of functional gastrointestinal disorders, especially those aggravated by emotional tension.

Specific Clinical Applications: Functional gastrointestinal disturbances, pylorospasm, peptic ulcer, gastritis, spastic colon (irritable bowel), biliary dyskinesia.

Dosage: One tablet three times a day.

Availability: Aqua-colored tablets containing 15 mg. of Pro-Banthine (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride). G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

SEARLE

MEMORIAL

to

DR. REDFORD A. WILSON

DR. WILSON was born Dec. 24, 1900 in Cadiz, Ky. He received his preliminary education in that vicinity and entered Vanderbilt University, Nashville, Tenn., in 1919.

He graduated from Vanderbilt University Medical School in 1926.

Following this, Dr. Wilson interned in the Louisville City Hospital from 1926-1927 and the New Haven Hospital, New Haven, Conn., 1927-1928.

He then received a fellowship at the Polyclinic in Memphis, Tenn., where he served from 1928 to 1929.

Later, he became associated with the Thomas-Davis Clinic in Tucson, Ariz., where he was from 1929 to 1953. In 1953, Dr. Wilson retired from active practice.

During this time, he was on the staff of St. Mary's hospital where his work will be long remembered.

Dr. Wilson is survived by his wife, Mildred, and two daughters, Mrs. R. L. Hollis of Yorktown, N. Y. and Mrs. J. C. Turpin Jr. of Tucson, Ariz., and his mother, Mrs. J. Scott Wilson, of Hopkinsville, Ky.

Dr. Wilson was very active in supporting the professional societies of medicine.

He was a Fellow of the American College of Physicians and of the American Medical Association. He was also a member of the American College of Chest Physicians, the American Trudeau Society, a Fellow of the American College of Allergists, and a Fellow of the American Academy of Allergists. In addition, he was a member of the Pima County Medical Society, and the Arizona Medical Association.

Dr. Wilson will long be remembered by his associates, patients and colleagues for his careful and kindly application of the art and science of medicine.

JOHN W. KENNEDY, M.D.

Topics of Current Medical Interest

THE ARIZONA MEDICAL ASSOCIATION, INC.

1958-59 ANNUAL REPORT OF THE SECRETARY:

SINCE April 1, 1958, 106 new members were admitted to our component county medical societies and this association as follows: Apache 0; Cochise 2; Coconino 6; Gila 4; Graham 0; Greenlee 1; Maricopa 75; Mohave 0; Navajo 3; Pima 12; Pinal 0; Santa Cruz 0; Yavapai 1; and Yuma 2. There are at the present time 997 members in the association compared with 901 members at this time last year. Membership by county is as follows:

Apache, 2; Cochise, 26; Coconino, 21; Gila, 22; Graham, 7; Greenlee, 7; Maricopa, 548; Mohave, 2; Navajo, 8; Pima, 264; Pinal, 29; Santa Cruz, 8; Yavapai, 21, and Yuma, 32.

The 997 total membership figure is broken down into the following classifications: Active 937 (including 50-Year Club); Service 23; and Associate 37.

Council has held seven meetings during the 1958-59 fiscal year: two were held in the San Marcos Hotel on April 29 and April 30, 1958; four at the Westward Ho Hotel, Phoenix, Ariz., on June 8, 1958, Sept. 14, 1958, Oct. 5, 1958 and Jan. 18, 1959; and one meeting was held at the Bagdad Restaurant of the Tucson Inn, Tucson, Ariz., on Nov. 23, 1958. Your council is next scheduled to meet on April 28, 1959 at 2:30 p.m. in the Little Room of the San Marcos Hotel, Chandler, Ariz. Each meeting has been well attended with representation from all areas of the state, and the business of your association continues to be handled with efficiency and despatch. The chairman of council undoubtedly will submit his report, including major items discussed and actions taken.

The Speaker of the house of delegates has submitted an annual report for your review.

Your delegate to the AMA has submitted his annual report for your review.

Annual reports also have been submitted for your review by four of your district councilors.

The air pollution committee held no formal meetings the last year, but has been active in regard to the problems as they pertain to Arizona.

The AMEF committee has again been extremely active, and its annual report is submitted for review.

The civil defense committee's annual report is submitted for review.

The constitution and by-laws committee has worked hard this year and will present to the house a complete proposed revision in your by-laws and certain recommended changes in your articles of incorporation. Its report is also submitted for review.

The fee and contractual medicine committee has held three formal meetings this year and a fourth is scheduled for April 27, 1959. Its report with a supplement thereto is submitted for review.

The history and obituaries committee has been extremely active, and its report and recommendations are submitted for review.

The industrial relations committee has performed in its usual efficient manner during the past year. Its report and recommendations are submitted for review.

The Medicare adjudication committee has served well during the year, and its report is submitted for review.

The ad hoc committee on poisoning control has held three formal meetings during the year, and a fourth is anticipated during the annual meeting in Chandler. Its report and recommendations are submitted in detail for review.

The report of the professional liability insurance investigating committee is submitted for review.

The professional liaison committee report and recommendations are submitted for review.

The public relations board was again quite active, though holding no formal meetings. Its report is submitted for review.

The combined and detailed report and recommendation of the editor-in-chief, *Arizona Medicine*, and the publishing committee are submitted for review.

The safety committee has submitted its report and recommendations for review.

The report of the co-ordinating committee on school health is submitted for review.

Actions of the advisory committee to the

women's auxiliary is given in its report submitted for review.

The professional board has held bi-monthly meetings for the past year, and its detailed report will no doubt be submitted for review.

The central office advisory committee has been extremely helpful to that operation, and its report and recommendations are submitted for review.

The griveance committee has been active, and its annual report will no doubt be submitted for review.

The legal services committee report and recommednations are submitted for review.

May I say that the council of your association, together with the membership of the various committees and boards, have completed, in my opinion, another year of satisfactory and effective accomplishments. Each has been well aware of his duties and responsibilities and has served with distinction and merit. The administration of the business of the association, with ever-increasing detail required, under the direction of the executive secretary, continues to give a good accounting of his stewardship.

It has been my privilege and a pleasure to serve you during the past fiscal year, and I wish to thank each and every member of the association for their complete co-operation, indulgence and support.

Respectfully submitted,

LESLIE B. SMITH, M.D.,
Secretary

1958-59 ANNUAL REPORT OF THE LEGISLATION COMMITTEE:

THE LEGISLATION committee of The Arizona Medical Association, Inc., has held one meeting so far this year, which convened at Hotel Westward Ho, Phoenix, Ariz., Feb. 15, 1959. This meeting was held during the first regular session of the 25th Legislature of the State of Arizona, primarily to consider urgent matters requiring immediate action.

HB 265 — Cancer Case Reporting

HB 265 was introduced Feb. 24, 1959, an act relating to public health and safety; providing for reporting contagious neoplastic diseases to the state department of health, and amending section 36-621, Arizona revised statutes.

In line with action of the house of delegates, May 3, 1959, and direction of council, Nov. 23, 1958, such legislation was recommended; however, it was the hope that the names and addresses of patients be not included in such reporting, substituting therefor some means of statistical verification. Considerable study was given the matter in the hope of satisfying such name identification elimination, but it was determined practically impossible to keep track of a cancer case by code number, bearing in mind that a patient might have been admitted to several hospitals in Arizona, not always by the same attending physician and at the time of death of the individual, still another physician might be in attendance. It was concluded to provide for the reporting of the cancer case by name on a confidential basis, not open to public inspection, except that such report may be used for study by licensed members of the medical profession. This measure cleared the house, however, it was not reported out of the committee in the senate, principally because there was strong objection to the reporting of a patient's name by a very influential senator. Effort should be continued in the new year to realize the enactment of suitable legislation to effect adequate cancer case reporting in the State of Arizona.

SB 220 — Osteopathic Practice Act Amendments

SB 220 was introduced Feb. 23, 1959, an act relating to professions and occupations; prescribing the composition of the state board of osteopathic examiners, prescribing the compensation of members of the state board of osteopathic examiners and the secretary-treasurer thereof; regulating the practice of osteopathic physicians and surgeons; regulating the osteopathic board fund; regulating the qualifications, examination and licensing of applicants; establishing the fee for renewal of licenses; regulating the rights and duties of osteopathic physicians and surgeons and the revocation or suspension of licenses; regulating the filing of complaints by the state board of osteopathic examiners; prescribing penalties for violations and amending sections 32-1801, 32-1802, 32-1804, 32-1805, 32-1822, 32-1825, 32-1851 through 32-1858 Arizona revised statutes.

The committee was early apprised of the anticipated introduction of legislation by the osteopathic group primarily to grant privilege to license doctors of osteopathy unlimited in the

practice of medicine and surgery in Arizona. Currently, osteopathic physicians are licensed to practice medicine and upon certain additional observation and training over a period of two years based on osteopathic standards, may be certified to do major surgery in this state. In other words, doctors of osteopathy initially receive a limited license.

Approximately eight weeks prior to the convening of the 24th Legislature of the State of Arizona, the osteopathic group released a series of weekly newsletters addressed to all members-elect of the legislature, setting forth the history of osteopathy, training, colleges, virtues of the practice, etc., with the final issue timed for release at the convening of the legislative session in early January. Among other things, a 12 months' internship was provided as a means to compensate for the extension of full surgery privileges; and an attempt to delete, wherever possible, the use of the designation "Osteopathic" when referring to physicians and surgeons and in substitution thereof requiring only the affixing of the initials, D.O., immediately following the name of the licentiate. Other changes had to do with administrative procedure of which there appeared no objection.

The association strongly opposed the objectionable features of the measure and special comment is made referable to the excellent work of its legal adviser, Mr. Edward Jacobson, in bringing about the tabling of the bill. It did not clear the senate. Unquestionably, effort will be renewed to achieve the objective in the second regular session of the legislature to convene in January 1960, and it is the hope that the house of delegates of the American Medical Association will again consider the osteopathic problem and possibly arrive at a conclusion during its forthcoming annual meeting in Atlantic City.

HB 212 — Sale of Raw Milk Prohibited

HB 212 was introduced Feb. 12, 1959, an act relating to dairies and dairying; amending the Arizona revised statues so that the law is in conformity with the United States milk ordinance and code as prescribed by Section 3-605, Arizona revised statues, and amending sections 3-606, 3-624, 3-634, and 3-342, Arizona revised statues.

In 1956, the Arizona State Legislature enacted a measure adopting the United States milk ordinance and code which prohibited the sale of raw milk within this state after July 1957. In 1957, effort was made to amend the act to legalize the sale of raw milk after the effective date of prohibition thereof. While this measure passed the house at that time, it was held up in the senate. In 1958, recognizing possible irregularities in the 1956 act, certain of the dairymen applied to the state dairy commissioner for a permit to sell raw milk. Litigation followed and finally Judge Robert S. Tullar ruled that the raw milk sections of the old code were not repealed through enactment of the 1956 legislation; accordingly, the dairy commissioner was forced to issue permits for its sale based on both the court ruling and opinion of the attorney general.

Recognizing that the sale of raw milk is a backward step in the progress of preventive medicine and public health, and that the continuing growth of Arizona will make raw milk a greater hazard than it has been in the past, this bill was introduced requiring pasteurization of all milk sold to the ultimate consumer for human consumption.

A public hearing was held jointly by the livestock and public lands and public health committees at which this association was represented in support of the measure because of the extreme hazards involved in the sale of raw milk, which is contrary to good public health practice, placing private interests above public health. While medicine made a good presentation in the interest of the health of the people, it appeared quite obvious that the interests of a relatively few private dairymen, including Mr. Davenport of Tucson, were to be given special consideration, particularly did the comments of Rep. Waldo L. DeWitt and Rep. Sidney Kartus support such contention. Their prejudices in favor of the dairymen and their unwillingness to recognize the health and welfare of the vast majority of the citizenry, who are opposed to the sale of raw milk, undoubtedly contributed much to the withholding of the measure in committee. The association should renew its efforts to achieve the objective sought in prohibiting the sale of raw milk to consumers for human consumption during the second regular session of the legislature and more strongly oppose the selfish interests of a minority who would sacrifice the health and well-being of the citizenry to gain privilege for a relatively few dairymen. Fortunately, during the interim the public will have some protection through control of its production by the Arizona State Health Depart-

ment requiring certain minimum standards.

SB 166 – Chiropractic Practice Act Amendment

SB 166, an act relating to professions and occupations; regulating the practice of chiropractic; prescribing the salary of members of the board of chiropractic examiners; amending Sections 32-903, 32-906, 32-921 through 32-925, Arizona revised statutes, and amending Title 32, Chapter 8, Article 2, Arizona revised statutes, by adding Section 32-928, provided in the main for a number of administrative changes in which there appears no objection insofar as medicine is concerned; however, the amended Section 32-922 providing for examinations of out-of-state licensees included the additional subjects, "chiropractic X-ray technique and interpretation" and "diagnosis." Such expansion of the practice of chiropractic was strongly opposed and deleted prior to the passage of the bill by both the senate and house. Here again, our legal adviser successfully achieved an important objective in the interest of the health and welfare of the citizenry.

Twenty-Fourth Legislature – Arizona

There were, of course, a number of other measures of varying importance considered by the Arizona legislature, including (a) control of air pollution, (b) more rigid narcotic regulation, (c) licensure and advertising control of the practice of chiropody and (d) numerous measures designed toward better traffic control and safety, including more severe penalties for the drunken driver. Each was given adequate study, together with many others dealing with health and welfare of our citizenry, included in the approximately 600 measures introduced in both houses of the legislature.

Miscellaneous

Your committee continues to give consideration to such items including, but not limited to, (a) qualifications of a state health commissioner, (b) review board composite involving sterilization procedures, (c) amendments to the Medicine and Surgery (medical practice) Act, (d) poisoning and hazardous substance control, (e) optometric practice in determination of blindness in public assistance cases and (f) service-connected and non-service-connected medical care for veterans.

Federal Legislation

While many bills have been introduced in the 86th congress, first regular session, dealing with health and welfare problems, possibly two of the more important measures have been given due consideration by medicine. You are all familiar with the so-called Forand bill, HR 9467, introduced in the 85th congress which would provide, among other things, for hospital, nursing home and surgical services for eligible old age survivors. A similar measure has again been introduced in the 86th congress, numbered HR 4700, and it is anticipated before adjournment that much activity will be observed in both houses through efforts to amend the Social Security Act extending these additional privileges. Medicine, as you know, is opposing the measure. The Keogh-Simpson bill was approved by the house providing tax deferment for self-employed, including physicians and dentists, who place money into pension and retirement funds. It now goes to the senate for consideration. A similar measure was likewise approved by the house during the 85th congress; however, it failed of senate approval. The medical profession, along with other professional groups, including the American Bar, have long supported the enactment of such legislation and will continue to do so through this session in the hope of achieving the objective. Many other federal bills will require consideration and due vigilance on the part of your committee, opposing those objectionable and supporting those designed in the best interest of the health and welfare of the people.

On behalf of the membership of the legislation committee, your chairman wishes to express its appreciation for the opportunity to be of service and privilege to represent this association in matters legislative.

Respectfully submitted,

REED D. SHUPE, M. D.,
Chairman,
Legislation Committee

1958-59 ANNUAL REPORT OF SOUTHWESTERN DISTRICT COUNCILOR:

DURING the past year, the counselor has attended each meeting of the council and aided in carrying on the business of the association. In the Southwestern District, the primary problem which was handled involved the Parkview Hospital of Yuma and the members of the Yuma County Medical Society. The controversy was the result of the board of directors placing in the by-laws of the staff certain regulations which would allow the board to choose all officers

of the staff and allow the administrator to attend and vote at each committee meeting.

A majority of the doctors of Yuma objected to these regulations and refused to apply for positions on the staff unless these regulations were removed. A small group of doctors joined the staff without objection and placed certain of their group as officers and committee members. The counselor made several trips to Yuma in attempting to aid in settling the controversy. Council gave permission to Doctor William Manning and Doctor Lindsay Beaton to take whatever action was necessary and these men with the executive secretary, Robert Carpenter, and the legal counsel, Mr. Edward Jacobson, held a meeting with each of the factions and thus aided in securing the settlement of the controversy. The final settlement was made by the establishment of by-laws without the objectionable features, by the resignation of the previously elected staff officers, and the organization of new staff.

In the opinion of this counselor, the doctors of Yuma should be commended for taking a strong stand in preventing the usurping of the rights of doctors in hospitals by the administrative department. They had to undergo harsh criticism by the public papers and by many of their colleagues who were not informed of the basic issues behind the dispute. By standing strongly behind their principles, they succeeded in maintaining the right of self government in their hospital staff and thus did a great service for all doctors.

This counselor suggests that the council take steps to set up an investigating and arbitration group to handle similar disputes in the future so that such problems as this can be settled before they involve the entire community as did this controversy. He believes that such a group could have taken a more active part in the Yuma difficulties and secured a settlement several months before the final settlement was reached.

Respectfully submitted,

JAMES T. O'NEIL, M.D.,
Councilor,
Southwestern District

1958-59 ANNUAL REPORT OF THE MEDICAL ECONOMICS COMMITTEE:

THIS HAS been an inactive year as far as the medical economics committee per se, has been concerned. No direct problems have been placed within our jurisdiction for the past year. As a consequence, no meetings of the medical economics committee were held, inasmuch as the chairman could see little justification in holding a meeting "just to hold a meeting." However, please don't let me mislead the membership. Many major problems involving economics of The Arizona Medical Association, Inc. and its duly constituted membership have been going on. These, however, have been extremely capably handled by the special committees appointed to handle same and have been reported upon by their respective very capable chairmen. I refer specifically to:

(a) Fee and contractual medicine committee – Hayes W. Caldwell, M.D., chairman.

(b) Medicare and Medicare adjudication committees – Paul B. Jarrett, M.D., chairman.

(c) Insurance and planning committee – Noel G. Smith, M.D., chairman.

The activities of all these committees certainly is to be deeply commended. The committee on fee and contractual medicine has especially had an active and, I believe a successful year.

The policy of your committee chairman has been to, as astutely as possible, refrain from fostering or implementing any new economic measures even if public law, which obviously are of a socialistic trend and which would only serve as another wedge deeper into the establishment of socialized medicine. Along this line, I refer specifically to Public Law 880 (former House Bill 7225) passed by the 84th congress and now, since 1957, activated in many of the states. To refresh your memory, this law provides for increase in public assistance benefits to certain welfare cases, at present of a restricted, classified nature, but as to the future heaven only knows. To implement it, it would necessitate The Arizona Medical Association, Inc. recommending to the State of Arizona Legislature that this would be a wise move, inasmuch as the State of Arizona would have to provide for matching funds to meet those put out by the United States government. This problem has been under careful scrutiny by its subcommittee

chairman, Doctor John L. Cogland of Phoenix, for the past two years. Doctor Cogland and his committee advised caution, from the start, which is exactly the way your chairman felt. Reports from most of the states that promptly jumped on the bandwagon and implemented it early in its program, have been filled with disgust and apprehension – fully flavored with what they consider distinct socialized and state medicine control. I may refer specifically to our great neighbor to the west, California. All reports from California verify the above statements and vindicate Doctor Cogland's words of caution of proceeding slowly on this. We have, consequently, done our best to leave this socialistic law die of inertia.

We have, still confronting us, HR 4700 (the Forand bill). At present this is still tied up in committee in congress. We pray that it never gets out of committee.

I wish to thank all committee and subcommittee members and chairmen for their efforts throughout the past year. The membership at large also, for their tolerance and understanding of our efforts. I trust that all remember that it is frequently wise not to be too hastily active on new measures – i.e., repeating the worn, but so completely true – "Fools jump in – etc., etc."

Respectfully submitted,

FRANK W. EDEL, M.D.,
Chairman,
Medical Economics Committee

1958-59 ANNUAL REPORT OF THE MEDICARE COMMITTEE:

IT COSTS a tremendous amount of money to train a modern military technician, and the armed services soon found that most of this investment was benefiting private industry when the enlisted man refused to sign up for another hitch. In investigating the causes for dissatisfaction, it was found that insufficient fringe benefits existed to compensate for the shrinkage in the purchasing power of the pay envelope. Medical care existed as a fringe benefit only if the installation commander concluded he had the facilities, and then there seemed to be no great and burning desire on the part of numerous drafted and disgruntled young medics to compete with their professional comrades-in-arms in rendering the most prompt and personal service. A sergeant's wife might wait for hours in a cold and drafty hall for a routine pre-partum check to find that five o'clock had arrived and she should return tomorrow. Since salary was independent of desire or ability to please, this was indeed a socialistic form of captive patient (and doctor too, in the case of the drafted or draft-threatened "volunteer" doctor). The sergeant's wife had no assurance that the doctor who saw her pre-partum would be in attendance at her delivery or that he had any special skill or interest in obstetrics for that matter.

The consequences of these and other situations resolved the congress to increase fringe benefits, and since private medical care for dependents seemed to be an important feature in influencing re-enlistments, the Medicare program was enacted and became the law of the land in short order and without conferring with national medical leaders. The original program reminds us of the song, "C'mon-a-my house, I'm-a-gonna geeve-a-you every a-theeng!" The trouble was that no one knew what "every-a-theeng" was going to cost, especially when the defense department had to negotiate fee schedules for each and every state and territory. The theory behind this was that an M.D. in Philadelphia, for example, who had a neighborhood practice and office in his home might have a lower overhead than a doctor in Arizona who by custom, offices in a medical building, and therefore requires higher fees.

Those of us who negotiated the fee schedule in Washington had very little time to work on it before presenting our case to the defense department team, and were in the unenviable position of dickering for something we really weren't sure we wanted. To refuse to co-operate with the law of the land smacked of un-Americanism, especially when we had been complaining that drafting doctors to take care of civilians was socialized medicine. To insist that this program was likewise socialized medicine had us talking out of both sides of our mouths; we didn't like it when the military took care of civilians, and we didn't like it when civilians took care of civilians under military auspices. As a matter of fact, we didn't like anything until we negotiated a good fee schedule.

The importance of this fee schedule was not to be underestimated, because whether we wanted to take care of enlisted men's dependents on a basic service schedule or not, this fee sched-

ule would be used as a precedent and a unity basis for every other program to be forthcoming, both governmental and private. We had some reason to believe that this was only the beginning of this sort of thing, and still believe it, although not happily.

The fee schedule agreed upon was supposed to be a maximum fee schedule, the doctor was to bill his usual fee in cases where his usual fee was less, but this was like handing Uncle Lushwell a martini and saying, "Only the olive, mind you!" The schedule was actually a generous one, the best of any state, topping California by 10 cents a unit. Some of our members took a look at the schedule and concluded the millenium had arrived and that they had been handed a carte-blanche to recover their taxes and then some. In co-operation with their partners they consulted with each other on every case. They gave anesthestics for each others' T&As and then consulted to determine if the youngster could stand the anesthetic. Some did their own Pap smears and X-ray work or in co-operation with an associate, did routine pre- and post-partum cervical smears, routine X-ray pelvimetry on all pergnancies. Some had relations in the drug business and the high-powered prenatal vitamins and minerals prescribed boosted the cost of a pregnancy by another "C" note. We were likewise amazed to discover that nearly every dependent in these hands had a baker's dozen of unsightly large lesions on their visage which required extensive removal and delicate plastic repair. As time went on, these various cases presented more and more special problems which necessitated billing an additional amount for "special consideration." This reminded me of during the war when going through Reims after the Germans left, one could buy a liter of champagne for the equivalent of 35 cents American money. Going through on the way home, the newest vintage cost $6.50.

One Arizona doctor made $50,000 in one year from Medicare cases alone. We had one instance in which a surgeon billed his regular fee for an infant with bilateral herniae and hydrocele instead of the greater amount available. It is my understanding that this doctor's therapist has bespoken a grave prognosis.

The adjudication committee tramped hard on a few of our colleagues, but in other states the "let's all get our feet in the trough" tactics sent the cost of the program spiraling. Congress took a horrified look at the bill, called in a few ancient admirals and generals for advice, the same ones who will soon become joint commission inspectors, and decided they hadn't intended the benefits to be so un-fringe like, and promptly called a halt to the all-inclusive aspects of the program. This was poor psychology because no one likes an "Indian giver!" To offer and provide these benefits and then decide it costs too much and limit the services, is a bad morale builder. So in effect, congress did a worse job of what they started out to do than if they had left the whole thing alone. Such penuriousness in the face of millions to Tito doesn't sit well with doctors or enlisted personnel, but this is not germane to this discussion.

Since the change, we haven't had a single case to adjudicate. We aren't seeing many Medicare patients, either. In keeping with the economy mandate, the services are now flying their dependents to California or Texas for care in military hospitals. The cost of transportation comes out of another fund, but they always manage to dip into the same pocket.

Feel that hand in YOUR jeans?

Respectfully submitted,

PAUL B. JARRETT, M.D.,
Chairman,
Medicare Committee

1958-59 ANNUAL REPORT OF THE FEE AND CONTRACTUAL MEDICINE COMMITTEE:

THE FEE and contractual medicine committee has met on two occasions, in September and December of 1958. We are currently planning to meet with the Arizona Industrial Commission sometime in February 1959.

The first meeting of the committee was to invite various specialty groups to comment upon their fee schedule and our attempts to negotiate with the industrial commission. They were invited at this time to air their complaints about the present temporary fee schedule in hope that these might be remedied at future meetings with the industrial committee. At this same meeting, these various specialty groups were requested to prepare a cost analysis of their own practice so that slides might be prepared to present to the industrial commission highlighting the in-

crease of cost for practicing medicine and help establish, on this basis, a need for a sharp increase of our fee schedules to be realized from the industrial commission.

The following doctors from their different groups attended this meeting: John Cogland, Arizona Society of Internal Medicine; Carlos C. Craig, Arizona Academy of General Practice; R. Lee Foster, Arizona Society of Radiology; Fred H. Landeen, Arizona State Society of Anesthesiology; Morris E. Stern, Arizona Society of Anesthesiology; Donald McNary, Arizona Society of Dermatology; Dermont Melick, Arizona Society of Chest Physicians; Mahlon D. Prickett, Anesthesiology, Kenneth Rew, Psychiatry; Lorel A. Stapley, Arizona Society of Pathology; Robert H. Stevens, Arizona Society of Allergy; Laddie Stolfa, Urology.

The second meeting held Dec. 14, was used to review the reports that we have had from various medical groups to prepare slides and information for the industrial commission meeting. At this meeting we also decided that in some fashion the industrial commission should be shouldered with the burden of raising the fees of the medical society if they require an extension of the study period to establish proper fee schedules. We have had suggestions that they will not be prepared in our February meeting. At this meeting also it was decided that we should insist in our bargaining with the industrial commission that our fee schedules with them be on the same basis as the Medicare fee schedule program. Another suggestion which has merit and which has been discussed informally with the committee members is that the industrial commission be advised, if we are unsuccessful in our negotiations with them in February, that the present fee schedule is no longer in existence and that all of the members of the medical profession in Arizona will be advised to bill the industrial commission on their usual fee basis. The medical profession in the state of New York took this step last year. This approach would force the industrial commission to bestir themselves and stop what is felt to be a delayed tactics maneuver in which the past year and one-half they have failed to come to a satisfactory agreement with the medical profession. Furthermore, this is in no sense a strike against the industrial commission, and we are not refusing to take care of their patients. All in all, I think this approach is the proper one if the council and the medical profession will agree.

At this same meeting, the committee interviewed Mr. Edward T. Price who is negotiating to establish some sort of fee schedule for the builders union group in the State of Arizona. We urged Mr. Price to contact the Arizona Blue Cross and Blue Shield program to see if this wouldn't meet his needs and objectives. We advised him further that we are unable to make a committment for the state group and that this can be done only by council.

Finally, at this meeting various medical care plans and their negotiations were discussed. Despite the medical profession objecting to third party medical care, it seems that we are already doing this. We are doing it with the industrial commission, with Medicare, and with our own Blue Cross and Blue Shield group. It seems that we are going to be forced into some such approach in the future and this is another policy decision that must be made by the council.

The Pima County Medical Society requested our impression regarding the plan that they have proposed to insure a large industrial firm in which 90 per cent of the employes and dependents will be covered, and there will be a deductible amount of $100. The fee schedule being considered was the California Medical Association relative value schedule with a conversion factor of five. It was felt by the committee members present at this last meeting that this was a favorable fee schedule and, if agreeable by council, should be adopted.

Another program that might be reviewed by the council is the Long Beach physician health plan fee schedule. This is the California fee schedule with the addition of a cost-of-living index to control the future fee schedules. In a letter from the Los Angeles County Medical Society executive secretary "we tied this schedule in with the consumers cost-of-living index with the Long Beach-Los Angeles area, using January 1957 as a basis. The index at that time was 119.6. It has now risen 5 per cent and our fees have been adjusted upwards 5 per cent over the enclosed schedule effective Jan. 1, 1959. Once yearly in the future the consumer cost-of-living will re reviewed and fees will be adjusted either upward or downward to the next 5 per cent. When adjustments are made, they will not apply during the term of a contract in force on that date, but will apply to all extensions of previous contracts and all new contracts. Eighty-

five hundred people are covered under this plan and an additional 10,000 will be covered in the next 60 days. This method of attaching the fee to the consumer cost-of-living index has met a completely favorable response from the general public, management, union, and the physician members of the plan. Our plan is open to all members of the medical association. We have a nine-man governing board composed of physician members elected by the entire physicians' membership."

Respectfully submitted,
H. W. CALDWELL, M.D.,
Chairman,
Fee and Contractual Medicine Committee

1958-59 SUPPLEMENTAL ANNUAL REPORT OF THE FEE AND CONTRACTUAL MEDICINE COMMITTEE:

THIS IS a supplementary report of the fee and contractual medicine committee after their most recent meeting with the industrial commission.

The industrial commission presented their figures which indicate that their costs for medical procedures have steadily climbed since September starting out at 19 per cent and finally in mid-December being 31 per cent greater than previously paid for procedures. They are unable to state when they feel that this percentage climb will level out, but would anticipate that it would level out at about 35 per cent and hope that it will stabilize at this level in two or three months. They will plan to advise us with the latest figures before the next state medical meeting. In the course of their presentation, they again pointed out that the fees the doctors receive under the existing plan allows them a 35 per cent increase over the 1953 rate. That is, the industrial commission pays the physicians of the state 35 per cent more than they paid them in 1953. They know and recognize that certain fee schedules, such as the anesthetists, have been actually lower under the present schedules. When they have completed their studies with their IBM machines, they should be able to inform us what the fee schedule, using the 500 factor will do to their medical costs. In the course of their arguments, the industrial commission points out that the 1953 schedule was agreed to by the profession as being adequate and they are reluctant to raise our fee schedules more than 35 per cent above this level. They also point out that studies of fee schedules in surrounding states have revealed that Arizona physicians are paid very favorably in comparison to other states.

We advised the industrial commission that New York State physicians had set a precedent by charging the industrial commission their usual fee schedules and with this method had been able to persuade the industrial commission in New York to come to a more justified fee schedule. We advised them that many members of our society had suggested that we follow this precedent. We advised them that this bargaining had been prolonged over a long period of time and that the medical profession had been most patient and had borne the brunt of this delay from an economic standpoint. We also advised them that many of the specialty groups would not be satisfied with the present fee schedule and would be coming to them as groups to seek raises in their fee schedule. When they inquired of us as to what we thought would be an adequate fee schedule, we advised them that the 500 factor is what we consider an adequate fee schedule.

Other orders of business at the meeting included a letter to Doctor Fisher at the veterans' hospital advising him that the Medicare fee schedule would be considered adequate for the out-patient care of veterans in this area. We rejected the fee schedule proposed by the veterans' administration.

Doctor Francis M. Finlay volunteered to represent this state in a study of the relative fee schedule program to be held in San Francisco in the near future.

Respectfully submitted,
HAYES W. CALDWELL, M.D.,
Chairman,
Fee and Contractural Medicine Committee

1958-59 ANNUAL REPORT OF THE AD HOC COMMITTEE ON POISONING CONTROL:

THREE meetings of the ad hoc committee have been held in conjunction with faculty members of the College of Pharmacy of the University of Arizona, in May 1958, September 1958, and January 1959, with another one planned during the annual meeting of The Arizona Medical Association, Inc., in Chandler.

The committee recommended that Doctor Albert L. Picchioni of the College of Pharmacy, be made director of the Arizona poison control program. This recommendation has received the approval of council.

Doctor Frederick Beckert joined the committee in place of Doctor Paul Jarrett.

Eighteen Poison Control Treatment Centers have been activated in hospitals throughout the state and are receiving information service from the Poison Control Information Center. A letter has been sent to all the treatment centers asking that a member of the hospital staff be appointed as supervisor in order that the proper functioning of the center may be maintained. To date only three hospitals have replied.

There is still difficulty in obtaining satisfactory reports from poisoning cases. Where the attending physician or resident has filled in the forms, the information is of far more value than when it has been done by a record room clerk. The committee inserted a notice in the Pima County Medical Association monthly news letter asking for the co-operation of the practicing physician in filling out these forms.

The College of Pharmacy is available at all times to give help on poison information. During university hours, call MAin 4-8181 Extension 661. After hours, or on weekends and holidays, a member of the faculty of the College of Pharmacy may be reached by phone at one of the numbers below: Doctor Picchioni, MAin 4-6457; Doctor Chin, EAst 6-2600; Doctor Brewer, AXtel 8-2473.

An exhibit is being planned for the annual meeting of The Arizona Medical Association in April if sufficient funds are available.

The committee viewed a film, "One Day's Poison," and recommended it for showing to lay groups. This film may be borrowed from the state health department by contacting Mr. John Nelson, health-education division.

Attached to this report is a copy of the annual report of the Poisoning Control Information Center giving in detail their activities for the year 1958.

Respectfully submitted,

VIRGINIA M. COBB, M.D.,
Chairman,
Ad Hoc Committee on Poisoning Control

ARIZONA POISONING CONTROL INFORMATION CENTER:

College of Pharmacy,
University of Arizona
Annual Report of Activities
(Jan. 1, 1958 - Dec. 31, 1958)

A. *Arizona Poisoning Control Information Files*

In February 1958, the master file of poison information cards was competed. Approximately 1,500 of these 5 x 8 information cards were prepared by members of the Arizona Medical Association's poison control committee. Another 600 of the poison information cards were supplied by the National Clearinghouse for Poison Control Centers, Washington, D. C. These information cards are intended to supplement the toxicological information presented in textbooks, such as the popular Gleason, Gosselin, and Hodge, "Clinical Toxicology of Commercial Products."

Through the use of a Thermofax duplicating process, 18 sets of the Arizona Poison Information Cards were prepared. By June 1958, each of the 18 Arizona Hospital Poisoning Control Treatment Centers listed below were supplied with a set of the files. In almost every case, a representative from the Arizona Poisoning Control Information Center presented the files to the hospitals. In most instances, the representative met with the administrator, nurse-in-charge of emergency room, and the chief pharmacist to explain the proper use and maintenance of the files.

Since July 1958, approximately 150 additional poison information cards have been added to each of the files.

Hospital Poisoning Control Treatment Centers in Arizona Receiving Poison Information Files

Phelps Dodge Hospital, Ajo; Douglas Hospital, Douglas; Flagstaff Hospital, Flagstaff; Sage Memorial Hospital, Ganado; Grand Canyon Hospital, Grand Canyon; Holbrook Municipal Hospital, Holbrook; Mohave General Hospital, Kingman; McNary Hospital, McNary; Maricopa County Hospital, Phoenix; Good Samaritan Hospital, Phoenix; Memorial Hospital, Phoenix; St. Joseph's Hospital, Phoenix; Prescott Community Hospital, Prescott; Safford Inn Hospital, Safford; Pima County General Hospital, Tucson; St. Mary's Hospital, Tucson; Tucson Medical Center, Tucson; Yuma County General Hospital, Yuma.

In response to
innumerable requests
from dermatologists

***Winthrop Laboratories
now makes available***

TRIQUIN®

FOR LUPUS ERYTHEMATOSUS AND LIGHT-SENSITIVITY ERUPTIONS

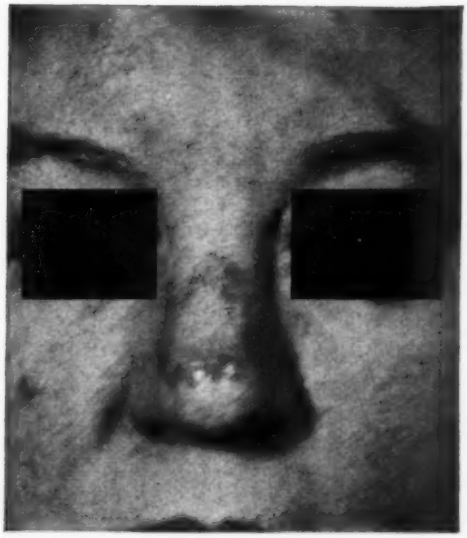
WHAT IT IS:
A combination of Atabrine® hydrochloride 25 mg., Aralen® phosphate 65 mg. and Plaquenil® sulfate 50 mg.

WHAT IT'S FOR:
Treatment of lupus erythematosus (chronic discoid type) and polymorphic light eruptions (light-sensitivity eruptions, solar urticaria or dermatitis).

HOW IT ACTS:
Each of the three components produces beneficial response in lupus erythematosus and light-sensitivity eruptions. Since the dose of each of the Triquin components is very low, overall toxicity is reduced and clinical tolerance improved. Furthermore, the three components appear to act synergistically.

HOW SUPPLIED:
Triquin tablets in bottles of 100, sold on prescription only.

Write for TRIQUIN booklet.



DOSAGE:
Lupus. Average initial adult dose, 1 or 2 tablets after meals and at bedtime. Dosage should be reduced gradually at two week intervals to 1 or 2 daily.

Light-Sensitivity Eruptions. Average initial adult dose, 1 tablet after breakfast and lunch. May be reduced after several weeks to maintenance dosage of 1 tablet daily.

Triquin, Atabrine (brand of quinacrine), Aralen (brand of chloroquine), and Plaquenil (brand of hydroxychloroquine), trademarks reg. U.S. Pat. Off.

Winthrop LABORATORIES New York 18, N. Y.

B. *Poison Case Reports*

Seven hundred and forty-one Arizona poisoning cases were reported to the Arizona Poisoning Control Information Center during the year 1958. The statistical breakdown of these cases is presented below. Case reports were received from 16 of the Arizona Hospital Poisoning Control Treatment Centers, with the majority of cases being reported from the Phoenix and Tucson centers. No reports have as yet been received from the Yuma Poisoning Control Treatment Center, or from the center located in St. Joseph's Hospital, Phoenix.

In most cases, the poison case reports have been completed by the medical records department of the hospital. For the most part, these reports have not been entirely satisfactory, since in many instances they are incomplete.

In approximately five of the hospital treatment centers, the physician treating the poison cases completes the report form. These reports have been excellent. It is hoped that more of the treatment centers will follow this example.

(SEE ADDENDUM FOR STATISTICS OF POISON CASES.)

C. *Participation of the Arizona Poisoning Control Information Center in Poison Control Programs*

(1) Fifteen poison control talks were presented to PTA groups, service clubs, and church organizations. The theme of these presentations was "prevention of accidental poisoning." Participants in these programs were: Willis R. Brewer, Ph.D.; Albert L. Picchioni, Ph.D.; Joseph A. Zapotocky, Ph.D.; Jack R. Cole, Ph.D.; and Loyd E. Burton, M.S.

(2) A poison control skit was presented at the Tucson YWCA on Dec. 4, 1958, and was open to the public. The skit depicted the operation of a poison control center in the treatment of an accidental poisoning case. Members of the skit were: Marguerite S. Williams, M.D.; Willis R. Brewer, Ph.D.; Albert L. Picchioni, Ph.D.; Mrs. Frederick Hirsch; Mrs. Grace Schell, and members of the Tucson Women's Club.

(3) A 10-minute television program was presented July 18, 1958, over Channel 4, KVOA, Tucson. The program concerned the operation of the Arizona Poisoning Control network. Speaker was Albert L. Picchioni, Ph.D.

(4) State and national poison control programs:

(a) Arizona Medical Association's committee on poison control presented a report on Arizona poison control at the Arizona Medical Association convention, Chandler, Ariz., May 2, 1958. Participants were Virginia M. Cobb, M.D., and Willis R. Brewer, Ph.D.

(b) Arizona Pharmaceutical Association convention program, held in Phoenix, April 12, 1958. Report on progress of Arizona poisoning control by Willis R. Brewer, Ph.D., and Albert L. Picchioni, Ph.D.

(c) Panel discussion on poison control centers held at the Los Angeles meeting of the American Society of Hospital Pharmacists, April 23, 1958. Panel was moderated by Henry L. Verhulst, assistant director of the National Clearinghouse for Poison Control Centers. Albert L. Picchioni, Ph.D., representing the Arizona Poisoning Control Information Center, was a panelist.

(5) Arizona State Health Department meeting:

Three representatives from the Arizona Poisoning Control Information Center, namely Willis R. Brewer, Ph.D., Albert L. Picchioni, Ph.D., and Lloyd E. Burton, M.S., met with 12 officials of the Arizona State Health Department on Dec. 4, 1958. The matter of reporting accidental poisoning cases to the Arizona Poisoning Control Information Center was discussed. An important outcome stemming from this meeting is a proposal for legislation which would make poisoning cases reportable to the state department of health. This has been submitted for action to the present legislature in session.

D. *Arizona Poisoning Control Information Center News Bulletin*

The Arizona Poisoning Control Information Center News Bulletin is published monthly. It is intended primarily to furnish the Arizona Hospital Poisoning Control Treatment Centers with current toxicological information, and statistics on poisoning incidents occurring in Arizona. The News Bulletin is published in the journals, *Arizona Medicine* and *Arizona Pharmacist*. Through the University of Arizona news bureau, the News Bulletin is made available to every Arizona newspaper, radio and TV station.

E. *Miscellaneous*

Albert L. Picchioni, Ph.D., consultant to the Arizona Medical Association's poison control committee, was appointed to the national com-

mittee, "Publications and Technical Information" of the American Association of Poison Control Centers.

ALBERT L. PICCHIONI, Ph.D.,
Consultant,
Poison Control Committee,
The Arizona Medical Association, Inc.

ADDENDUM
STATISTICS OF 741 POISON CASES FOR THE YEAR JAN. 1, 1958-Dec. 31, 1958

	Per Cent	*Number*
Age:		
Under 5 years	68.3	506
6 to 15 years	5.2	39
16 to 30 years	10.4	77
31 to 45 years	7.3	54
Over 45 years	5.7	42
Not reported	3.1	23
Nature of Incident:		
Accidental	87.3	647
Intentional	12.5	93
Not reported	0.2	1
Outcome:		
Recovery	99.1	734
Fatal	0.5	4
Outcome unknown	0.4	3
Time of Day:		
6 a.m. and noon	28.3	210
Noon and 6 p.m.	36.0	267
6 p.m. and midnight	20.7	153
Midnight and 6 p.m.	3.0	22
Not reported	12.0	89
Causative Agents:		
Aspirin preparations	26.5	196
Sedatives (barbiturates, antihistimines, tranquilizers)	13.8	102
Other medication	9.7	72
Solvents (paint thinner, kerosene, gasoline, turpentine, etc.)	12.0	89
Inecticides	7.8	58
Household cleaners and bleaches	5.2	39
Ornamental plants (castor beans, oleanders, Bird of Paradise, etc.)	2.3	17
Cosmetics	0.5	4
Paints	0.4	3
Miscellaneous household commodities	21.6	160
Poison unknown	0.2	1

1958-59 ANNUAL REPORT OF THE INDUSTRIAL RELATIONS COMMITTEE:

THE ARIZONA Industrial Relations Committee has met the first Monday of every month from June 1958 and will conclude its last meeting the first Monday of June 1959.

At the June organizational meeting, Doctor L. L. Tuveson of Phoenix, Ariz., was elected chairman of the industrial relations committee. The members of the committee were Doctor Philip G. Derickson of Tucson, Doctor Francis M. Findlay of San Manuel, Doctor Frederick W. Knight of Safford, and Doctor Kenneth G. Rew of Phoenix.

The committee this year has had no major problems brought before it by the industrial commission or by the Arizona Medical Association. In the past, the fee schedule has been organized by the Arizona Industrial Relations Committee and the new fee schedule was instituted on Aug. 1, 1958 which was to be an interim fee schedule allowing the industrial commission to study the impact of the increased fees on their fund at which time additional negotiations would be undertaken, not by the industrial relations committee, but by a new committee organized by the state medical association which was named a committee on fees and contractual medicine.

The members of the industrial relations committee would recommend to the president of the Arizona Medical Association and the councils that the industrial relations committee should be increased to six members and would recommend that a neurosurgeon be added to the consulting group.

The industrial relations committee has acted traditionally as the medical advisory board to the industrial commission, and the work load has progressed to the point where a neurosurgeon as a member of the board to examine the cases presented before the committee would be desirable.

The chairman at this time wishes to acknowledge the co-operation of the executive secretary and the assistant executive secretary of the Arizona Medical Association, Mr. Robert Carpenter and Mr. Paul R. Boykin, in their response to the many requests that the chairman has made from the central office. The chairman wishes to thank the other members of the industrial relations committee for their co-operation in at-

tending the meetings of the committee and has valued their counsel and friendship.

Respectfully submitted,

LEO L. TUVESON, M.D.,
Chairman,
Industrial Relations Committee

TRANSFER OF PREPAID MEDICAL SERVICES FROM BLUE CROSS TO BLUE SHIELD:

THE CHAIRMAN reported briefly on the status of request of the Arizona Society of Pathologists for the transfer of prepaid medical services from Blue Cross to Blue Shield.

A summarization of Doctor Schwartzmann's report on this subject will be submitted for discussion at the next meeting.

SUBCOMMITTEE REPORTS:

Aging

The executive secretary reported on a special meeting he attended, called by the AMA Council on Medical Service in conjunction with the activities of the AMA Committee on Aging, held in Denver, Colo., Thursday, Feb. 19, 1959, for the purpose of outlining a proposed regional meeting to include 11 of the Western states (Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming). This is to be a "pilot" undertaking in an endeavor to bring together those individuals and agencies especially interested in the problem of aging, or as more recently referred to, the problem of our "senior citizens." This suggested meeting is currently planned for Salt Lake City, Utah, on May 8, and 9, 1959.

Considerable discussion was held on the subject, it being recognized that it is the desire of AMA to have all the constituent state associations join with it in promoting this meeting and issuing invitations to any and all civic, fraternal, industrial, labor, professional and other groups; however, it is likewise recognized that there are many implications and possible involvements in such a venture. It is also recognized that this association can ill afford not to participate in meetings of this nature, if only to keep abreast of developments and informed at all times as to what is going on.

It was determined that the professional board should express its opinion to council of the association i.e., that it should not invite these groups or their representatives to attend the meeting, but rather call their attention to the fact that the meeting is being scheduled, and that if they choose to be represented, they will be welcome; and that the association should not be bound as a responsible party to the endeavor, but reserve the right to observe the proceedings and result thereof, keeping free to make its own decisions and establish its own position pertaining to the problem at a time of its own choosing.

It was moved, seconded, and unanimously carried that the professional board remommends to council that Doctor Jesse D. Hamer, delegate to the AMA, be designated representative of this organization to attend the scheduled meeting in Salt Lake City, May 8-9, 1959; further, that the professional board is of the opinion that we (the association) should continue to take part in these meetings; and that we give notice to the various organizations (of which AMA recommends contact), apprising them of the meeting in Salt Lake City, if they care to attend.

Crippled Children

Doctor Fife briefed the board on the current status of a survey of crippled children's facilities in the State of Arizona, which will aid in determining how the activities might best be coordinated for greater coverage of these services, indicating a report will be rendered at a later date.

The chairman referred certain literature received from AMA, dealing with the problem of rehabilitation, to Doctor Fife, determining that this phase of medicine would be added to this subcommittee's scope of operation.

Doctor Semoff raised a question as to whether or not it might be wisdom to contact all the specialty groups in Arizona, requesting each to appoint or designate a liaison representative, so that the individual subcommittee chairmen of this board would more readily obtain through them at any time an expression of attitude of the respective group on any given subject.

The chairman requested the executive secretary to write each of these societies, informing them of the increasing number of problems being presented to this board for consideration, advising that it feels the need for liaison with each such group and requesting that each select one, two or three of their members with whom our subcommittee chairmen may confer.

Hard of Hearing

Doctor Kinkade reported on the program of the "hard of hearing" conducted within the schools in the state advising that it is proceeding well and that the school nurses are doing a commendable job in this regard. Through the aid of the crippled children's societies, clinics have been set up for all school children in Douglas, Nogales, Flagstaff, Phoenix, and Yuma.

Doctor Kinkade also reported on the untimely demise of Lydia Newton, the result of an automobile accident about a month ago in San Francisco. Miss Newton had been sent to this area by the National Crippled Children's Foundation, to put this program on its feet. At the time of her demise, she was regional director for all the Western states. Doctor Kinkade commented: "We have lost a very good and faithful friend and a great worker."

The report on hard of hearing was accepted.

Hospital and Nursing Problems

Doctor Ross, in his absence from this meeting, submitted a written summary of his conclusions following review of the proceedings of the Western Council on Higher Education for Nursing, March 1958, on the subject: "Nursing Education" — Today — Tomorrow — The Day After That. He stated that it is an attempt to chart the course of what the general public probably considers to be a new profession, though some of the speakers consider that nursing might still be in the category of a vocation, or considered so generally. Mention is made of the licensed practical nurse program and the fact that the state association or the state boards of licensure of nursing pretty well control this. A relatively new program which is classed as terminal, a term which is in this case misleading, is that of the associates in arts program of nursing of the California junior colleages. Briefly, as a result of two years of study and practical work, this work controlled by the junior college, the graduates are eligible to write the State Board Test Pool for licensure as a registered nurse. The next program in nursing is the baccalaureate program. This program provides for the first of college degrees in nursing. Practically 50 of the 71 accepted program have sufficiently high accrediting that the graduate here is qualified for beginning positions in public health. There is a graduate program following the baccalaureate program. The speakers feel that this program is in its infancy. They advise, however, that broad expansion and extension of these specialty training accredited programs are indicated and they will be of the greatest advantage in gaining professional acceptance. Mention has not been made of the R.N. program with which we are all familiar. These programs differ, in the main they are a nursing educational program, the responsibility of the individual hospital. It is true that there are college level and collegiate courses, however, and in the greatest number of these programs, there is college credit which can be used toward the baccalaureate program. Your attention is called here also to the development of the terminal program in California, the associate in arts program of the California junior colleges, and the fact that these young women accomplish their R. N. by graduating from this course. This pretty well shows the preparation required of nurses today, nursing tomorrow and the day after that, is pretty speculative, as at one place in this report the duty of the nurses is defined as that of performing for a sick person that that he would do for himself if he were well, and many of the speakers feel that with the development, the duty of the nurse probably will be more that toward the community rather than the individual.

Doctor Ross further advises, in written report, as relates to Doctor Salsbury's report of an inspection of North Mountain Hospital, brought before this board at its meeting held Aug. 10, 1958, that the board's offer to designate surgeons as a part of Doctor Salsbury's inspection team has not been replied to. It is presumed that the findings of that team, should it be developed by Doctor Salsbury, would be presented to the state board of medical examiners.

Doctor Salsbury stated: "We'll request it."

The report on hospital and nursing problems was accepted.

Maternal and Child Health

Doctor Semoff reported on the polio program in co-operation with the Arizona Society of Pediatrics and the AMA. It has been determined to initiate a drive to make all families aware of the recommendation that they all have three injections of polio vaccine, and that all county medical societies meet with the local health department creating study groups to survey the polio immunization problems and work out a program to solve them.

Doctor Semoff recommended that this board recommended to council that we proceed along the lines of recommendations of the house of delegates of the AMA stating: "I think three phases are necessary. The first phase should involve all pre-school age children; then the children in school of all ages; then, particularly pointing out, that those adults under age 40 are still in a highly susceptible group; and then, asking everybody, regardless of age, to get the three shots because there is still plenty of vaccine available. The matter of the fourth polio shot must be mentioned because of the publicity it has had. I would recommend also that we co-operate completely with publicity informing all individuals of the polio inoculation program, especially those who have not been inoculated, placing the pressure on the county societies to implement such publicity rather than from the state level.

It was reported that a bill introduced in the state legislature prohibiting the sale of raw milk in Arizona was apparently defeated in committee.

Doctor Semoff reported that a state-wide convention of the Arizona League for Nursing was scheduled to be held in the Hi-Way House, Phoenix, on April 3 and 4, the theme to be: "Arizona's Maternal and Child Health Problem." He indicated that he planned to be present during the meeting, representing this association.

It was moved, seconded, and unanimously carried that we accept Doctor Semoff's resolution to the council referrable to the revitalization of the polio inoculation program with re-education and publicity on it.

Mental Diseases

Doctor Gregory reported that in December 1958, Joel B. Jepson, of the mental health education unit of Smith, Kline and French laboratories, directed a letter to the association inquiring as to whether or not there were any available seminars or programs in Arizona where a general practitioner or other specialists could get training in psychiatry.

Doctor Gregory advised that the matter of post-graduate study in psychiatry for the general practitioner was one of the specific areas of discussion which was taken up at the Fifth Annual Conference of Mental Health Representatives, held in Chicago, Nov. 21 and 22, 1958. A few conclusions were reached which were:

1. One of the main purposes of the Council on Mental Health of the American Medical Association is education in mental health of the medical profession in the broadest sense of that word. It was felt that perhaps, at a future conference, discussion might be devoted to the single topic of how such information might best be disseminated by state medical association representatives.

2. It was generally agreed that lectures are a poor way of post-graduate teaching, and it was generally agreed that clinical demonstration, coupled with case study groups would probably be the most effective.

3. The need for education of the general practitioner in psychiatric thinking was also pointed up as a resultant of the fact that geographical distribution of psychiatrists finds them, for the most part, grouped in three broad areas, the two coasts and the Midwest.

Doctor Raymond Feldman, of Bethesda, Md., pointed out that there are grants from the National Institute of Mental Health, specifically ear-marked for the training of physicians engaged in the practice of medicine in fields other than psychiatry. This program has two purposes. One of these is to provide postgraduate training in psychiatry for physicians who actually remain in their pre-training specialty or general practice. This would include general practitioners, internists, pediatricians and the like. The other purpose of the program is to provide financial support on an adequate level for post-graduate training for physicians in practice who wish to become psychiatrists. In this area there are available stipends up to a maximum of $12,000 per year.

As for Arizona, there is no organized program of psychiatric education for physicians. The psychiatrists in Maricopa County do have weekly meetings at which various and sundry aspects of their specialty is discussed. Our state hospital is not approved for residency training. Also, there is no private general hospital in the entire state that has an adequately equipped, staffed and organized psychiatric service.

Seminars

Doctor Schwartzmann, referring to the need for liaison with the specialty groups in the state, the apparent need for education on polio, aging, mental health and other medical problems, raised a question on the feasibility of this board recom-

mending to council that it be appointed a permanent program committee for the scientific sessions of the association's annual meetings. It was hoped that continuing membership of the professional board would provide a continuity of program material for the better education and information of the profession in this regard, replacing the activities of the subcommittee on seminars, which has apparently outlived its usefulness. It was suggested that the board might consider requesting the scientific assembly committee to allocate a given amount of time, perhaps two or three hours of the scientific meetings, to the board for its seminar program.

The executive secretary was requested to pass these thoughts along to council for its review and direction.

State Department of Health – Legislation

Doctor Salsbury informed the board that a bill presented to the state legislature requesting $52,000 for the purpose of equipping a state health department laboratory in Tucson had been cut by the legislature to $35,000, which amount would not suffice for establishing the laboratory, and requesting the board's help in re-establishing the need for the laboratory and the need for $52,000 to do the job.

It was determined that members of the board would attempt to interest the Pima County Medical Society in this regard, if it was felt needed.

Tuberculosis

Doctor Farness reported on Senate Bill 125, currently before the Arizona State Legislature having to do with an appropriation for the Arizona State Tuberculosis Sanatorium, with no recommendation. He further stated that the Arizona State Tuberculosis and Health Association in co-operation with the Arizona State Health Department, has planned a program for pilot skin testing and X-rays. This association will provide the medical clinic.

COMMUNICATIONS:

HEW – X-ray Survey of Silicosis in Metal Mines

The department of health, education, and welfare, by letter dated Dec. 5, 1958, reporting on survey of metal miners in Arizona by the bureau of mines-public health, advised that operations of the survey team began Nov. 3 in Wyoming, continuing in Utah and then in Arizona by late December, with examinations beginning at the Magma mine near Superior, Jan. 5. The team will move from there to Miami. As the team moves into a new area, the county health officers and local medical societies will be informed of the general operation.

The National Foundation

Doctor Semoff indicated that he planned to attend the regional meeting of the National Foundation to be held in San Francisco, Wednesday, March 4, 1959. Doctor Schwartzmann requested a report on the meeting to be presented to the professional board at its next meeting.

A news letter of the National Foundation announces a new nationwide network of treatment and evaluation centers for aiding America's millions of arthritis and rheumatism sufferers to be supported with March of Dimes funds to be raised in the current campaign. Doctor Schwartzmann stated that Arizona has many good, well organized and active clinics raising funds and using them wisely. He further stated that perhaps we had better find out what the feelings of these established organizations in Arizona are before we start fostering more confusion and expense for the job to be done. It was suggested that we contact the rheumatism and arthritic foundation, both in the southern and northern part of the state, the Arizona Society for Crippled Children and Adults and the Cerebral Palsy Foundation and find out their feeling referrable to the moving in of the National Foundation in these fields, and then, when Doctor Semoff reports, we can submit a resolution in this regard to council.

OTHER BUSINESS:

Subcommittee Files

Doctor Schwartzman referred to the continuing files of each subcommittee chairman and again requested that they be kept complete at all times. As members peruse the daily newspapers, every once in a while something will appear that pertains to some of these board meetings. It was further suggested that such articles be cut out and placed in such files which may well be of tremendous import and help in the future.

Annual Report of the Professional Board

Doctor Schwartzmann reported that the annual report of the professional board, which will include a summarization of the business before this board during past meetings, should be completed as early as possible and he requested that each subcommittee chairman forward to him within the next week or 10 days any business to be included.

UNIVERSITY OF ARIZONA LIBRARIES

Subcommittee on Crippled Children

The chairman announced the appointment of Doctor Ray Fife as chairman of the subcommittee on crippled children.

Subcommittee on Aging

Doctor Schwartzmann directed the central office to continue to press the 14 component county medical societies for a response, either positive or negative, as regards the recommendations of this board at its meeting of Dec. 7, 1958.

Industrial Relations

Doctor Schwartzmann reported a need for one of the board's subcommittees to work with the industrial relations committee regarding transferring of industrial patients from one physician to another, particularly as pertains to the ethics involved. It was determined that this problem be assigned to the subcommittee on crippled children.

Whiplash Injuries

The Western Orthopedic Association advises that it is the unanimous opinion of the members of the group that the term "cervical whiplash" is a completely untenable term and all attempts should be made to exclude it from medical literature. It is their feeling that the term should have some clarification, both among doctors and lawyers, but that this should be on a sound, scientific basis.

It was determined that the board recommend to council that after receiving information from the various professional groups in the state concerned, referrable to the term "cervical whiplash," as related to neck injuries in medical-legal problems, that, as applied generally to this type of injury, it is considered poor terminology; and that this board recommends that those of the medical profession who use it in court, qualify the term with the actual mechanics which result in neck sprain.

LESLIE B. SMITH, M.D.,
Secretary

RESOLUTIONS SUBMITTED, 1959 MEETING

INTERPROFESSIONAL CODE FOR PHYSICIANS AND ATTORNEYS

RESOLUTION

WHEREAS, the American Bar Association and the American Medical Association have recently adopted a *NATIONAL INTERPROFESSIONAL CODE FOR PHYSICIANS AND ATTORNEYS:* and

WHEREAS, The State Bar of Arizona recognizes the great desirability of promoting closer and better relationships between the professions of law and medicine, and between the individual practitioners of these professions, to the end that the public interest and the administration of justice will be served; and

WHEREAS, the State Bar of Arizona believes that the adoption of a joint declaration between it and the Arizona Medical Association is a significant and desirable means to that end,

NOW, THEREFORE, BE IT RESOLVED that the State Bar of Arizona, in convention assembled, does hereby adopt the following Declaration, said Declaration to be effective upon its adoption by the Arizona Medical Association:

JOINT DECLARATION OF THE STATE BAR OF ARIZONA AND ARIZONA MEDICAL ASSOCIATION OF THE PRINCIPLES APPLYING TO THE RELATIONSHIP BETWEEN PHYSICIANS AND ATTORNEYS

PREAMBLE

The provisions of this Declaration are intended as guides for physicians and attorneys in their inter-related practice in the areas covered by its provisions. They are not laws, but suggested rules of conduct and courtesy for members of the two professions. This Declaration is subject to the basic precepts of medical and legal ethics, and to the rules of law governing the practice of these professions.

This Declaration recognizes that with the growing inter-relationship of medicine and law, it is inevitable that physicians and attorneys will be drawn into steadily increasing association. It will serve its purpose if it promotes the public welfare, improves the practical working relationships of the two professions, and facilitates the administration of justice.

MEDICAL REPORTS

The physician upon proper authorization should promptly furnish the attorney with a complete medical report, and should realize that delays in providing medical information may prejudice the opportunity of the patient either to settle his claim or suit, delay the trial of a case, or cause additional expense or the loss of important testimony.

The attorney should give the physician reasonable notice of the need for a report and clearly specify the medical information which he seeks.

CONFERENCES

It is the duty of each profession to present fairly and adequately the medical information involved in legal controversies. To that end, pre-trial discussions between the physician and the attorney are encouraged and recommended. Such discussions should be had in all instances unless it is mutually agreed that they are unnecessary.

Conferences should be held at a mutually convenient time and place. The attorney and the physician should fully disclose and freely discuss the medical facts and opinions involved in the controversy.

SUBPOENA OF MEDICAL WITNESS

Because of conditions in a particular case or locality, or because of the necessity for protecting himself or his client, the attorney is sometimes required to subpoena the physician as a witness. Although the physician should not take offense at being subponaed, the attorney should not cause the subpoena to be served without prior notification of the physician. The duty of the physician is the same as that of any other person to respond to judicial process.

ARRANGEMENTS FOR COURT APPEARANCES

It is recognized that the courts, in the administration of justice, cannot function for the convenience of lawyers or witnesses. Nevertheless, advance arrangements for the attendance of physicians as witnesses can and should be made. Reasonable notice to the physician should be given and the lawyer should advise the physician by telephone as to the approximate time of his required attendance. The demands upon the professional time of a physician should be considered, and every effort should be made to conserve his time.

PHYSICIAN CALLED AS WITNESS

The attorney and the physician should treat one another with dignity and respect in the courtroom. The physician should testify solely as to the medical facts in the case and should frankly state his medical opinion. He should never be an advocate and should realize that his testimony is intended to enlighten rather than to impress or prejudice the court or the jury.

It is improper for the attorney to abuse any witness. It is equally wrongful for an attorney to seek to pervert or improperly influence a physician's honest medical opinion. On the other hand, the physician should not mistake strenuous cross-examination for abuse. The established rules of evidence afford ample opportunity to test the qualifications, competence and credibility of a medical witness. The physician should not be oversensitive in the face of cross-examination, and the attorney should never deliberately embarrass or harass the physician.

FEES FOR SERVICES OF PHYSICIAN RELATIVE TO LITIGATION

The physician is entitled to reasonable compensation for time spent in conferences, preparation of medical reports, and for court or other appearances. These are proper and necessary items of expense in litigation involving medical questions. The amount of the physician's fee should never be contingent upon the outcome of the case or the amount of damages awarded.

PAYMENT OF MEDICAL FEES

The attorney should do everything possible to assure payment for services rendered by the physician. When a claimant's physician has not been fully paid, the attorney should request permission of the claimant-patient to pay the physician from any recovery which may be made.

IMPLEMENTATION OF TH'S DECLARATION AT LOCAL LEVELS

In the event similar action has not already been taken, this Declaration should, in the public interest, be appropriately implemented at county or city levels for the purpose of improving the inter-professional relationship between the legal and medical professions.

CONSIDERATION AND DISPOSITION OF COMPLAINTS

The public airing of any complaint or criticism by a member of one profession against the other profession or any of its members is to be deplored. Such complaints or criticism, including complaints of the violation of the principles of this Declaration, should be referred by the complaining doctor or lawyer through his own association to the appropriate association of the other profession; and all such complaints or criticism should be promptly and adequately processed by the association receiving them.

The foregoing Resolution was duly adopted, etc.

President

Secretary

HOUSE OF DELEGATES

RESOLUTION

Introduced by W. Shaw McDaniel, M.D., dele-

gate, Maricopa County Medical Society.

Subject: Socialized Medicine — Its Avoidance Through Non-Participation in Government Medical Contracts.

WHEREAS, there now exists in the Congress of the United States, both in the senate and house of representatives, a clear majority whose election was accomplished through groups dedicated to socialistic principles of government, and who owe to such groups a certain allegiance, and

WHEREAS, one of the principal objectives of the socialistic planners in this and all other countries is the socialization of the medical profession as the initial step in further extension of the welfare state, and

WHEREAS, in every nation where socialized medicine has been forced on the people, the cost of the program has tended to bankrupt the economy while at the same time the quality of medical care, as a whole, has deteriorated, and

WHEREAS, there are in existence several government programs for care of various groups such as dependents of military personnel, and certain aspects of the veterans' program, and these programs are becoming increasingly and unbearably costly and are covering a greater segment of the population than was originally intended by congress, and

WHEREAS, there is no demonstrable need for changing the character of medical service in this country, especially in view of the rapid expansion of private insurance coverage for the health needs of the people, and

WHEREAS, the principle of free enterprise in this country since its founding has produced the most powerful and advanced nation in the history of the world, and

WHEREAS, the private practice of medicine, as one of the cornerstones of free enterprise, has resulted in the highest standards of medical practice, the greatest increase in longevity, and the greatest improvement in the general health of the people than in any other country,

THEREFORE BE IT RESOLVED, that the Arizona State Medical Association shall adopt the principle of non-participation in any scheme of socialization of the medical profession under whatever name or guise, and shall not enter into any new contracts with the federal government or any agency thereof which would further the advent of such government intervention between the doctor and the patient,

AND LET IT BE FURTHER RESOLVED, that the above principle of non-participation will not in any way endanger or change the traditional obligation of the doctors of the association to care for anyone in need of medical attention under the time-tested and proved methods for distribution of medical services known as the private practice of medicine.

RESOLUTION

Introduced by Graham County Medical Society, Thomas W. Jensen, M.D., president.

Subject: Diabetes Survey by State Department of Health.

WHEREAS, diabetes mellitus is not a public health problem, and

WHEREAS, The Arizona State Department of Health has been granted $33,000 for diabetes mellitus detection by the federal government, and

WHEREAS, we feel this is another invasion of the private practice of medicine on the part of federal and state government, and

WHEREAS, if the taxpayers are to be given relief from excessive taxation,

THEREFORE BE IT RESOLVED, that we the members of the Graham County Medical Society go on record and unanimously vote against the diabetes mellitus detection program as administered by the state department of health, and

FURTHERMORE, we request the Arizona Medical Association to go on record as to its attitude regarding this matter, and

FURTHERMORE BE IT RESOLVED, that while diabetes mellitus detection is a constant part of the private practice of medicine, that the Arizona Medical Association prepare and put into action a diabetes detection program done at the private physician level as has already been done in the past.

MEDICAL SUPPLY DIRECTORY

Arizona Medical Supply Co., Inc.

Phone MA 3-7581

1027 E. Broadway — Tucson, Arizona

Verna E. Yocum, Pres. George F. Dyer, V. Pres.
M. O. Kerfoot, Sec.

. . . IF CANCER STRIKES

H.B.A. CANCER INSURANCE PAYS UP TO $2,500.

YOUR CANCER POLICY PAYS FOR THE FOLLOWING EXPENSES:

HOSPITAL SERVICES • Room and board up to $20.00 per day. In addition it pays the usual and customary charges for such hospital services as: X-ray examination, X-ray therapy, Radium therapy ,operating room charges, laboratory tests, drugs and medicines, and any other services by the hospital which may be used in treatment.

MEDICAL SERVICES • The usual and customary charges made by physicians, surgeons, consulting physician or surgeon, assistant surgeon, anesthetist, pathologist, X-ray therapist, Radium therapist and any other medical service or treatment required in treating cancer.

NURSING SERVICES • Provides cost for up to three registered graduate nurses per day, $12.00 per nurse.

DRUGS AND MEDICINES • All drugs and medicines which may be required in treating cancer.

BLOOD TRANSFUSIONS • The usual and customary charges for transfusions including blood donor charges.

AMBULANCE SERVICES • Up to $25.00 ambulance expense in transporting patient to or from the hospital for each hospitalization.

TRANSPORTATION • Plane or train fare when being transported from one locality to another upon the recommendation of the attending physician to a lawfully operated hospital in the USA which provides treatment for cancer.

LOW COST

Only **$7.50** a year for the H.B.A. Individual Cancer Policy for persons under 55 years of age.

Only **$15.00** a year will protect your entire family, husband, wife, and all unmarried children under 18 years of age.

MAIL COUPON TODAY

or

CALL AL 8-4888

The H.B.A. Life Insurance Company

First Street at Willetta, Phoenix, Arizona

Please send me your free folder "IF CANCER STRIKES" without obligation.

NAME .....

ADDRESS .....

CITY ..... STATE .....

PHONE .....

ARIZONA POISONING CONTROL INFORMATION CENTER

EDATHAMIL DISODIUM NOW COMMERCIALLY AVAILABLE FOR MEDICINAL USE

ANOTHER preparation of ethylenediamine tetra-acetic acid (EDTA) or edathamil has been recently made commercially available for medicinal use as an antidote. It is the disodium salt of edathamil named Endrate Disodium by the manufacturer, Abbott Laboratories. It possesses the same properties of forming water-soluble, non-ionized complexes or "chelates" with certain metallic ions as does edathamil calcium disodium, which has been used with considerable success for several years in the treatment of acute and chronic lead poisoning.

The edathamil disodium preparation is available in 20 ml. ampuls containing 150 mg. edathamil disodium per ml. The solution must be diluted with 500 ml. of 5 per cent dextrose in water before use. The diluted solution is then administered by intravenous infusion during a period of not less than two-and-one-half hours.

Edathamil disodium is considerably more toxic (on a weight for weight basis) than edathamil calcium disodium. With the latter preparation, the calcium affinity of edathamil has been saturated, hence it does not disturb serum calcium levels. Present evidence indicates that the toxicity of edathamil disodium is dependent on both total dosage and speed of administration. No cases of severe hypocalcemia have been as yet reported with this preparation with the recommended dosage and rate of administration. It is suggested, however, that calcium gluconate for intravenous use be available when this preparation is used(1).

A unique application of edathamil disodium as an antidote has been in the treatment of severe digitalis intoxication. Gubner and Kallman(2) have reported the use of edathamil disodium in five cases of severe digitalis intoxication. Chelation of serum calcium by this chemical agent proved effective in abolishing both atrial and ventricular atopic rhythms caused by digitalis. These investigators concluded, "The use of edathamil disodium offers certain advantages over potassium administration in treating digitalis toxicity. Its action is prompt and is safer than intravenous potassium. Oral potassium is slow in effect and large doses are required which may not be well tolerated." In these studies, the usual dosage employed was 600 mg. edathamil disodium administered intravenously in 250 ml. of 5 per cent dextrose in water within a half-hour period.

ORAL USE OF EDATHAMIL IN TREATMENT OF ACUTE LEAD POISONING

It has been shown that edathamil calcium disodium given orally in the presence of lead in the intestinal tract is a very dangerous drug. Edathamil combines with lead salts in the gastrointestinal tract and promotes their rapid absorption into the blood stream and transport to the brain. It is believed that increased absorption of lead from the intestinal tract may also occur with intravenous administration of edathamil. Therefore, emptying the intestinal tract by enemata may be an important preliminary to treatment with edathamil irrespective of the route of administration. On the other hand, dehydration by severe catharsis would be undesirable(3).

POISONING CONTROL EXHIBIT AT ANNUAL CONVENTION OF ARIZONA MEDICAL ASSOCIATION

The Arizona Poisoning Control Information Center has been invited to present an exhibit at the annual convention of the Arizona Medical Association to be held in Chandler, Ariz., April 30 to May 2, 1959. In this exhibit, the current status of antidotes used in the prevention and treatment of toxic effects from chemical agents involved most frequently in poisoning incidents in Arizona will be emphasized. A unique movable cart, complete with drugs, instruments, and equipment useful in the treatment of poisoning, will be displayed. Home medicine cabinets possessing safety features such as an inside light and lock and key will be featured. Arizona ornamental plants involved in accidental poisoning in children will be included in the exhibit.

REFERENCES

1. Endrate Disodium, Instruction Circular, Abbott Laboratories.
2. Gubner, S. and Kallman, H., "Treatment of Digitalis Toxicity by Chelation of Serum Calcium", Am. J. Med. Sci., 234:136, August 1957.
3. Byers, R. K., "Lead Poisoning", Pediatrics, 23:585, March, 1959.

STATISTICS OF 167 POISONING CASES IN ARIZONA DURING FEBRUARY AND MARCH 1959*

	Per cent	Number
Age: Under five years	70.6	(118)
Six to 15 years	0.6	(1)
16 to 30 years	7.2	(12)
31 to 45 years	6.0	(10)
Over 45 years	7.8	(13)
Age not reported	7.8	(13)
Nature of Incident: Accidental	90.4	(151)
Intentional	9.6	(16)
Outcome: Recovery	100.0	(167)
Fatal	0.0	(0)
Time of Day: Between 6 a.m. and noon	24.0	(40)
Between noon and 6 p.m.	27.5	(46)
Between 6 p.m. and midnight	26.3	(44)
Between midnight and 6 a.m.	1.2	(2)
Time of day not reported	21.0	(35)

Causative Agents:

Internal medicines	Number	Per cent
Aspirin	31	18.5
Other analgesics	8	4.8
Barbiturates	29	17.3
Antihistamines	6	3.6
Laxatives	2	1.2
Cough medicine	2	1.2
Tranquilizers	3	1.8
Others	11	6.6
Subtotal	92	55.0
External medicines		
Liniment	3	1.8
Antiseptics	0	0
Others	0	0
Subtotal	3	1.8
Household preparations		
Soaps, detergents, etc.	3	1.8
Disinfectants	2	1.2
Bleach	3	1.8
Lye, corrosives, drain cleaners	7	4.2
Furniture and floor polish	4	2.4
Subtotal	19	11.4
Petroleum distillates		
Kerosene	4	2.4
Gasoline	5	3.0
Others	3	1.8
Subtotal	12	7.2
Cosmetics	5	3.0
Pesticides		
Insecticides	4	2.4
Rodenticides	1	0.6
Others	0	0
Subtotal	5	3.0
Paints, Varnishes, Solvents, etc.	12	7.2
Plants	4	2.4
Miscellaneous	11	6.6
Unspecified	4	2.4
Total	167	100.0

WILLIS R. BREWER, Ph.D.,
Dean, College of Pharmacy
The University of Arizona

ALBERT L. PICCHIONI, Ph.D.,
Pharmacologist and Director
Arizona Poisoning Control Program

LINCOLN CHIN,
Pharmacologist

*The poisoning cases included in this report for the month of February are in addition to those cases already reported for February in News Bulletin No. 3 (March 1959).

PASSANO FOUNDATION AWARD FOR 1959

THE board of directors of the Passano Foundation announce that Doctor Stanhope Bayne-Jones has been elected as the recipient of the $5,000 Passano Award for 1959.

On Wednesday evening, June 10, during the convention of the American Medical Association in Atlantic City, a reception and dinner will be held at the Traymore Hotel to honor Doctor Bayne-Jones.

Doctor Louis M. Orr, incoming president of the American Medical Association, will speak on Doctor Bayne-Jones's contribution to the practice of medicine. Doctor Joseph C. Hinsey, director, New York Hospital-Cornell Medical Center, will present Doctor Bayne-Jones's contribution to medical education.

This year's award is presented to Doctor Bayne-Jones in recognition of a long and extraordinary service to science and medicine as educator and administrator in tasks of the highest importance, in all of which he has served with distinction and faithfulness. His most recent post was that of chairman of the secretary's consultants on medical research and education, department of health, education and welfare. The extensive and very significant report made to the secretary of the department has become known as the Bayne-Jones report.

The Passano Foundation was formed late in 1943, having as its sole purpose the encouragement of medical science and research, particularly that having a clinical application. It is sustained by annual contributions from The Williams & Wilkins Company, publishers of medical and scientific books.

Past laureates of the Foundation are: the late Doctor Edwin J. Cohn (1945); Doctor Ernest W. Goodpasture (1946); Doctor Selman A. Waksman (1947); Doctor Helen B. Taussig and Doctor Alfred Blalock (1948); the late Doctor Oswald T. Avery (1949); Doctors E. C. Kendall and Philip S. Hench (1950); Doctors Philip Levine and Alexander S. Wiener (1951); Doctor Herbert McLean Evans (1952); Doctor John Franklin Enders (1953); Doctor Homer W. Smith (1954); Doctor Vincent du Vigneaud (1955); Doctor George N. Papanicolaou (1956); Doctor William Mansfield Clark (1957), and Doctor George W. Corner (1958).

ARIZONA STATE SOCIETY OF ANESTHESIOLOGISTS

AT THE recent Western Biennial Conference on Anesthesiology the Arizona State Society of Anesthesiologists held its annual meeting. The following were elected: President, Fred H. Landeen, M.D., P.O. Box 6055, Tucson, Ariz.; vice president, Paul S. Causey, M.D., 926 E. McDowell Rd., Phoenix, Ariz., and, secretary-treasurer, Allan B. Carter, M.D., P.O. Box 6055, Tucson, Ariz.

DRIVE-IN PRESCRIPTION WINDOW

PEOPLE'S DRUG STORE

111 E. Dunlap

WE 3-9152 — WI 3-9964

JOHN REEDER

Investment Manager

6839 North Longview — Phoenix, Arizona

AMherst 6-1221

Independent Professional Business Agent

Planning & Actively Managing Diversified Investment

Programs For Successful People In Arizona

REVOLUTIONARY NEW TABLE SPREAD CONTAINING 45% LINOLEIC ACID

NUTRISPREAD

The most economical and convenient source of polyunsaturated fats:
For adequate essential fatty acid supply • saturated fat replacement • cholesterol normalization

INDICATIONS

Diets requiring decreased animal or saturated fats.
Cholesterol control (therapeutic and prophylactic) in:

- Hypercholesteremia
- Atherosclerosis
- Diabetes
- Hepatic inadequacy
- Essential fatty acids deficiency states
- Coronary disease and cardiovascular pathology

All purpose food as a spread, for cooking and baking

Linoleic acid is accepted by medical authorities as the active principle (polyunsaturated linoleates) in the management of the above conditions.

HIGH PATIENT ACCEPTANCE

Excellent taste appeal — country fresh flavor.
No change in food pattern, no separate menus required.
Low salt. Reduced calories.
Low cost. Most palatable and economical source of polyunsaturated linoleates available, regardless of dosage form.
Conventional pound package, cubed for convenience.
Marketed through health food and grocery outlets.

For complete information on Nutrispread, write to
Dept. A-2
HALE LABORATORIES, INC.
10515 WEST PICO BLVD.
LOS ANGELES 64, CALIF.
Or telephone
Phoenix Representative CR 4-0474

If they need nutritional support . . .

they deserve

GEVRAL®

Vitamin-Mineral Supplement Lederle

CAPSULES—14 VITAMINS—11 MINERALS

LEDERLE LABORATORIES, a Division of
AMERICAN CYANAMID COMPANY, Pearl River, New York

BLUE SHIELD

PLEASE take notice that the following amendments of the Articles of Incorporation and the following amendments of the by-laws of Arizona Blue Shield Medical Service, an Arizona corporation, were offered for adoption by the membership at their annual meeting at 2 o'clock p.m., April 29, 1959, at the San Marcos Hotel, Chandler, Ariz.:

Proposed Amendment of Articles of Incorporation:

It is proposed that the first two clauses of Article IV be amended to read as follows:

"The general nature of the business proposed to be transacted and the powers of this corporation shall be:

"To maintain and operate an association for the purpose of providing medical care to the corporation's subscribers upon such terms and conditions as the corporation may from time to time determine, and to this end to make, amend, modify, rescind, and terminate contracts and to do and perform any and all acts deemed useful, convenient or necessary in providing for such medical care."

Proposed Amendments of By-Laws:

It is proposed that Article X of the by-laws be amended by the addition of Section 3 thereto, as follows:

"Sec. 3. Upon such terms and conditions as the board of directors may deem appropriate, and in such instances as it may determine to be for the best interests of this corporation, payment may be made to the subscriber rather than to the participating or non-participating physician who performed the services. In all such cases, payments may be temporarily withheld until the board of directors or the professional committee is reasonably assured that the payment will be applied by the subscriber for the purpose intended."

It is proposed that Section 5, Article XI, of the by-laws be amended to read, as follows:

"Sec. 5. Non-particpating physicians, fully licensed to practice medicine and surgery in Arizona, may be paid for services rendered a subscriber upon the approval of and as determined by the professional committee."

It is proposed that Article XII of the by-laws be amended to read, as follows:

"Any physician not having a participating physician's contract with Arizona Blue Shield Medical Service shall be considered a non-participating physician."

ARIZONA BLUE SHIELD MEDICAL SERVICE, INC.,
Carl A. Holmes, M.D.,
Secretary

• • •

The 1958 annual report of Arizona Blue Shield is indicative of the progress and expansion of the plan during the past year. "Nineteen fifty-eight represented an all time high in the matter of monies," according to L. Donald Lau, executive director for Blue Cross and Blue Shield, headquartered at 331 West Indian School Road, Phoenix.

Total Blue Shield income for the year just past was $2,455,696.40. Additions to reserves was 6.64 per cent. Operating expense for Blue Shield was the lowest in the nonprofit surgical-medical program since its inception in Arizona, being 11.03 per cent.

The annual meeting of Blue Shield was held at the San Marcos, April 29, in conjunction with the annual meeting of the Arizona Medical Association. The house of delegates of the association serving as the corporate body for Blue Shield, elected new board members, as well as the plan's officers and passed on new policy. Arthur C. Stevenson, M.D., is president.

Over 1,000 Arizona doctors of medicine are now participating physicians in this state's Blue Shield plan. Over 15 per cent of the state's population is enrolled in Blue Shield at present, according to Lau. "The Blue Cross report will be made later in conjunction with the annual Blue Cross meeting scheduled for May 17," he added.

BLUE CROSS — BLUE SHIELD

POETS and novelists have romanticized about the golden years since time immemorial. It would be pure sacrilege to attempt to duplicate their efforts. So we will leave such descriptive prerogative to those blessed with a far greater literary prowess. We do know, as a matter of fact, that today's senior citizen, the proud representative of the golden years, is a revered and respected human, possessing a depth of dignity and courage that is an inspiration to those of the younger generation. We know our senior citizen has a burning desire to live and learn . . . an insatible yearning to keep doing things . . . and we know for certain he is capable and desirous of providing for his present and future security and well-being, as well as those who are dependent upon him.

The senior citizen now finds himself with greater leisure time. This oviously opens up new channels and experiences to him. He can travel more and see things he has only read about; he can enjoy greater recreational activities as an active participant; he can pursue hobbies and vocations with greater enthusiasm. The modern miracles and wonderful developments of medical science make it possible for all of us to have an option on a longer life with less interruptions of our normal routine because of illnesses. Everyone directs more attention toward the senior citizen of this country. Today, he is considered truly one of the most important members of our society.

Now from the abstract to the factual. With the life expectancy having been greatly increased in recent years (nearly 20 years since 1900), greater provisions for the future must be considered. In the field of prepayment hospital and medical-surgical care we must do more for the senior citizen. We have talked about this for a number of years, and we did become most academic. Now it is time for action – positive and realistic action from us.

The senior citizen certificate is the Blue Shield way of working with the senior citizen . . . we feel that a person of over 60 should be given just as much consideration as anyone else. The senior citizen certificate has been designed to provide hospital and medical-surgical care for those over 60 years of age.

This year marks the latest step by Arizona Blue Cross-Blue Shield to bring nonprofit, prepayment hospital-medical-surgical care to those of over 60 years of age in this state. We are not alone in this effort, as other Blue Cross-Blue Shield Plans are engaged in similar programs for the senior citizens of their states. We are proud to be one of those joining in this humanitarian activity, and we take this means of calling this program to your attention.

The senior citizen certificate becomes another part of the general trend of providing medical care for our citizenry without depending upon any form of government to do the job. Voluntary action insures freedom and the democratic processes which naturally ensue. Don't you agree the voluntary way is the way to do this? This coverage was made available to Arizonans over 60 and in good health during the month of May with appropriate promotion of the event.

LOCATION OPPORTUNITIES

ASHFORK — Population 700 — North centrally located — Railroad center — Contact the Women's Club, Ashfork, Ariz.

CAMP VERDE — Located in the heart of a large farming and ranching area on the Verde River. Approximately 100 miles north of Phoenix. Badly in need of a medical doctor. Contact Ivy N. Moser, R.N., Camp Verde, Ariz.

EL MIRAGE — Population 2,000 — and including the trading areas of Surprise, Youngtown, Peoria and Luke Air Force Base the population is estimated at 7,000 to 8,000 persons. Opportunity for a GP due to retirement of doctor currently serving, with the possibility of school service. Climate is excellent, warm and dry. Office facilities are available and in the area surrounding El Mirage from Glendale (nine miles) to the east, and Wickenburg (35 miles) to the west there are only two doctors to serve this community. The need for an M.D. and/or surgeon is very real and one should do very well. For information write Mr. H. Faulkner, Town Clerk, Town of El Mirage, El Mirage, Ariz.

GILA BEND — Population 2,500 — 80 miles west of Phoenix — Nearest town to the Painted Rock Dam project — Good opportunity for GP. Cattle, cotton, and general farming. Office and equipment available. $150 monthly income from board of supervisors. Contact Mrs. J. F. Allison, Box 485, Gila Bend, Ariz.

GLOBE — Population 10,000 and including the mining and cattle areas of Miami, Superior, Ray, Hayden, Winkleman, Payson and San Carlos; population estimated at 30,000 persons. Located about one hour by car from either Tucson or Phoenix. No ENT man in the area. Will consider GP. New medical center, hospital, all church denominations, schools, clubs, etc. Ideal climate, with the best area for outdoor activities. Contact Eugene R. Rabogliatti, D.D.S., 149 S. Broad St., Globe, Ariz., or Ellis L. Pollock, M.D., Miami Inspiration Hospital, Miami, Ariz.

HAYDEN — Population 3,000/4,000 — Industrial practice — approximately 200 employes and dependents. Only part-time required. Coverage: Metropolitan Surgical Plan. Physician may engage in private practice also. Small company-owned clinical building (new) available for use, with X-ray equipment, diathermy equipment, etc. Full-time nurse available to assist; clerical work to be handled by company. Company housing facilities available for physician—small rental. Contact: American Smelting & Refining Company, Mr. Ben Roberts, department manager, P.O. Box 1111, El Paso, Tex.

MIAMI — Opportunity for GP — Industrial hospital staffed by approximately seven doctors, who care for personnel and families of those who work for the three principal mining companies. Community served by many mining and ranching interests. Contact Robert V. Horan, M.D., Miami Inspiration Hospital, Miami, Ariz.

MORENCI — Mining community near New Mexico - Arizona border. Population 10,000. Has vacancy at hospital for GP. Contact Carl H. Gans, M.D., Morenci Hospital, Morenci, Ariz.

PAGE — Population growing by leaps and bounds at the site of the new Glen Canyon Dam project. Current estimates are 6,000 to 8,000 total. Only one M.D. is now located in Page and he has facility available. Located about 90 miles north of Flagstaff, Ariz., the building project is estimated to be concluded in 10 years. Write Ivan W. Kazan, M.D., 6th Ave. & S. Navajo, Page, Ariz., for full details.

SAFFORD — Graham County Health Department in need of an M.D. In the heart of the cattle and farming areas of southeastern Arizona. Population of 10,500; elevation, 2,920 feet. Schools, churches and social facilities are numerous. Contact Mr. Verl Lines, chairman, Graham County Board of Supervisors, Safford, or Frederick W. Knight, M.D., 618 Central Ave., Safford.

ST. JOHNS — Seriously needs a doctor of medicine, preferably a GP, in this east-central Arizona community. Population is approximately 1,500 with several other small towns in the general area. About 20 miles from New Mexico in the beautiful rim country of Arizona. Contact Donald F. DeMarse, M.D., Box 397, Holbrook, Ariz.

TOLLESON — In need of GP. Serves a trading area of from 12,000 to 15,000. Ten miles west of Phoenix, with elementary and high schools, churches of all denominations. Complete office and equipment for GP is available on reasonable term lease or purchase. Contact Mr. F. E. Babcock, president, chamber of commerce, 9112 West Van Buren St., Tolleson, Ariz.

TUCSON — The VA Hospital is in urgent

need of an orthopedic surgeon. They prefer someone who is board certified, but would take someone who has had special training as they have the local men in this field available for consultation service. State license is necessary (but not necessarily an Arizona license). Contact S. Netzer, M.D., director, professional service, VA Hospital, Tucson, Ariz.

WINSLOW — Population over 7,500. Good opportunity for GP. Arrangements can be made to take over existing vacancy in practice. Facilities quite desirable and satisfactory terms can be arranged to suit any financial circumstance. Hospital privileges immediately available. County work also available at $500 per month plus lab and X-ray. For further details, contact Donald F. DeMarse, M.D., Box 397, Holbrook, Ariz., or Mr. Paul Gear, county supervisor, Court House, Holbrook, Ariz.

FOR INFORMATION ON OPPORTUNITIES IN THE FIELD OF INDUSTRIAL MEDICINE, CONTACT:

Harold J. Mills, M.D., Phelps Dodge Hospital, Ajo, Ariz.

Carl H. Gans, M.D., Phelps Dodge Hospital, Morenci, Ariz.

Ira E. Harris, M.D., Miami Inspiration Hospital, Miami, Ariz.

Charles B. Huestis, M.D., Box 928, Hayden, Ariz.

Elvie B. Jolley, M.D., Copper Queen Hospital, Bisbee, Ariz.

H. W. Finke, M.D., Magma Copper Company Hospital, Superior, Ariz.

John Edmonds, M.D., Kennecott Copper Corporation Hospital, Ray, Ariz.

Francis M. Findlay, M.D., San Manuel Hospital, San Manuel, Ariz.

LOCATION INQUIRIES

CAMMACK, JR., KIRK VERN, M.D., 1105 W. Paterson, Flint, Mich.; *S;* 1953 graduate of University of Colorado Medical School; interned and served residency at Hurley Hospital in Flint, Mich.; holds license in states of Michigan and Colorado; fulfilled military obligations; married; age 32; interested in assistant or associate practice or possible teaching position. Available July 1, 1959.

CASTIGLIA, EUGENE A., M.D., 46 Franklin Hill Ave., Boston 24, Mass.; *I;* 1955 graduate of Jefferson Medical School; interned at Polyclinic Hospital in Harrisburg, Pa.; served residency at VA Hospital in Albuquerque and Lahey Clinic in Boston; fulfilled military obligations; holds license in states of Pennsylvania and Massachusetts; married; age 32; interested in group or industrial practice. Available July 1959.

FUNCKES, ARNOLD J., M.D., 2240 Cordova, Youngstown, Ohio; *GP;* 1958 graduate of the University of Missouri; interned at Youngstown, Ohio; military status — 5A; holds license in the state of Missouri; married; age 32; interested in assistant or associate practice. Available July 15, 1959.

JESSEPH, JOHN ERVIN, M.D., 1702 30th Ave., South, Seattle 44, Wash.; *S;* 1953 graduate of the University of Washington; interned at King County Hospital in Seattle; served residency at University of Washington, King County Hospital and VA Hospital; holds license in state of Washington; applying for license in state of Arizona; fulfilled military obligations; married; age 33; interested in clinic, assistant or associate practice. Available January to June 1960.

LUCAS, JR., RUSSELL VAIL, M.D., 3142 44th Ave. South, Minneapolis 6, Minn.; *P;* 1954 graduate of the Washington University School of Medicine; interned and served residency at University Hospital in Minnesota; holds license in states of Missouri and Minnesota; military status — USAR active reserve; married; age 30; interested in clinic, assistant or associate practice. Available July 1, 1959 to July 1, 1960.

MILLER, CARL DON, M.D., 3016 Sanson Ave., Spokane, Wash.; *GP;* 1958 graduate of University of Nebraska; interned at Deaconess Hospital in Spokane; holds license in the state of Nebraska; fulfilled military obligations; married; age 32; interested in assistant or associate practice. Available July 1959.

RIPPLE, JR., RUDOLPH J., M.D., 1880 Ford Parkway, St. Paul, Minn.; *I;* 1953 graduate of University of Minnesota; interned at U.S. Naval Hospital in Oakland, Calif; served residency at veterans' hospital — University of Minnesota; holds license in state of Minnesota; fulfilled military obligations; married; age 30; interested in assistant or associate practice. Available October 1959.

RUSSELL, WILLIAM McKINLEY, M.D., 1570 Plum St., San Diego 6, Calif., *GS;* 1933

graduate of College of Medical Evangelists; interned at Los Angeles County General Hospital; served residency at Metropolitan Hospital in New York; holds license in the states of California and New York; military status – presently on active duty; married; age 59; interested in industrial practice – will consider institutional practice. Available Sept. 1, 1959.

SAND, BERNARD F., M.D., 1012 Superba Ave., Venice, Calif.; *GS;* 1953 graduate of Creighton University School of Medicine; interned at City of Detroit Receiving Hospital; served residency at Wadsworth Veterans' Hospital in Los Angeles; holds license in the states of Nebraska and California; fulfilled military obligations; married; age 36; interested in group, associate, institutional or private practice. Available July 1959.

SCHWEITZER, I. L., M.D., 1310 Oakdale, Freeport, Ill.; *I;* 1947 graduate of the University of Illinois; interned and served residency at Mercy Hospital in Chicago; holds license in the states of Illinois and California; military status – Class IV; married; age 35; interested in group practice. Available September 1959.

SMITH, VICTOR W., M.D., 5425 Brody Drive, Madison, Wis.; *CP-S;* 1954 graduate of University of Chicago; interned at Tripler Army Hospital; served residency at the University of Wisconsin and Methodist Hospital in Madison, Wis.; holds license in the state of Wisconsin; fulfilled military obligations; married; age 30. Interested in student health program of a university or college. Available September 1959.

WIZBOWSKI, RAYMOND V., M.D., 22000 Madison, Dearborn 8, Mich.; *GS;* 1952 graduate of the University of Michigan; interned at Wayne County General Hospital in Eloise, Mich.; served residency at Dearborn Veterans' Hospital and Detroit Receiving Hospital; holds license in the states of Michigan, Ohio and California; applied for license in the state of Arizona; fulfilled military obligations; married; age 36; interested in group or associate practice. Available immediately.

BONNINGTON, WILLIAM R., M.D., Sacramento County Hospital, Sacramento, Calif.; *GP;* 1957 graduate of the University of California; interned at Madigan Army Hospital in Tacoma, Wash.; served residency at Sacramento County Hospital; holds license in the state of California; fulfilled military obligations; married; age 31; interested in associate practice. Available July 1, 1959.

SITUATIONS WANTED

General Surgeon, 34, Married, Board Certified, F.A.C.S. Arizona License. Association desired with group or other surgeon.

Write:

ARIZONA MEDICINE
801 N. 1st Street
Phoenix, Arizona

Graduate of Northwestern University Medical School, 1951. Internship Charity Hospital of La, 3 Years. General Practice in Miss. Finishing 4th year of General Surgical residency, York Hospital, York, Pa., June 30, 1959. Board eligible. Intend to practice General Surgery including some GYN. plastic, Orthopodics, vascular, chest. Looking for place in Southern Arizona to practice either by self or in association. If you can offer information or are interested in associate.

Please Contact

James W. Grossnickle, M.D.

RD No. 3, York, Pa. — Phone 5-0619

WAYLAND

PRESCRIPTION PHARMACIES

TWO FINE STORES

North Central Medical Bldg.

2021 N. Central

and

Professional Building

13 E. Monroe

Phoenix, Arizona

FREE DELIVERY

RYan 1-9339

SYcamore 3-7193

2900 E. Del Mar Blvd.
(formerly Blanche Street)

Las Encinas

PASADENA, CALIFORNIA

LAS ENCINAS, sheltered in its own landscaped park, is conveniently located in Pasadena. Fully equipped for the clinical study, diagnosis and care of medical and emotional problems. Full-time staff of certified specialists in surgery, medicine and psychiatry. Rooms, apartments and suites available in main building or attractive cottages.

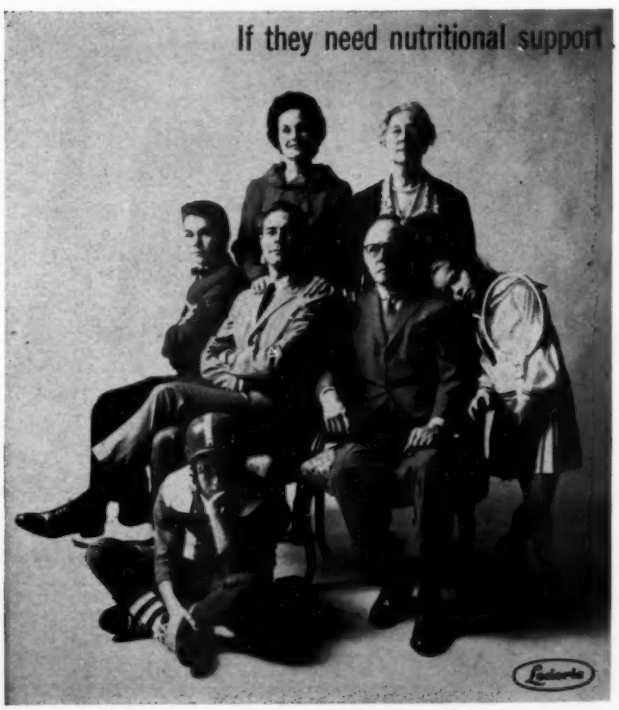
CHARLES W. THOMPSON, M.D., F.A.C.P., Medical Director

STAFF

CLIFTON H. BRIGGS, M.D., F.A.C.S. — KENNETH P. NASH, M.D.
ETHEL FANSON, M.D., F.A.C.P. — STEPHEN SMITH III, M.D.
DOUGLAS R. DODGE, M.D. — HARRIET HULL SMITH, M.D.
HERBERT A. DUNCAN, M.D. — JOHN W. LITTLE, M.D.
DONALD C. BALFOUR, JR., M.D.
GERTRUDE J. JACKSON, M.S., Psychology

WRITE FOR OUR ILLUSTRATED BOOKLET

If they need nutritional support . . they deserve



GEVRAL®

Vitamin-Mineral Supplement Lederle

CAPSULES—14 VITAMINS—11 MINERALS

Each capsule contains:	
Vitamin A	5,000 U.S.P. Units
Vitamin D	500 U.S.P. Units
Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate	1/15 U.S.P. Oral Unit
Thiamine Mononitrate (B_1)	5 mg.
Riboflavin (B_2)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Bitartrate	50 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I.U.
l-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

. . . a complete line of

SURGICAL SUPPORTS

Fitted exactly as you prescribe.

. . . for your patients' every condition — such as back strain, obesity, post-operative, viceroptosis, cardiac, emphysema, etc.

Hospital and home calls made at your direction.

Expert fitters, private fitting rooms.

Grove's Surgical Supports Store

3123 N. CENTRAL AVE.

PHOENIX ARIZONA

PHONE CR 4-5562

Serving Arizona

Health Needs

Since 1908

Ryan-Evans DRUG STORES

Phoenix - Tempe - Globe - Miami - Superior

Casa Grande - Glendale

Wickenburg - Tucson

Future Meetings

THE SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA

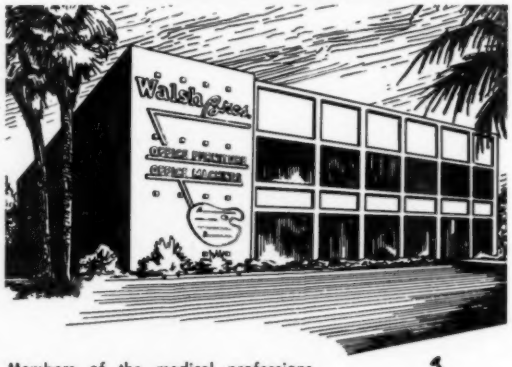
The School of Medicine, University of California, Los Angeles offers *Fetal Electrocardiography*, June 5-6, 1959; *Office Urology*, June 17, 1959; and *Surgical Technique Utilizing the Isolated Intestinal Segment in Urological Procedures*, June 18, 1959.

UNIVERSITY OF CALIFORNIA SUMMER SEMINARS

Three summer seminars at the University of California, Residential Conference Center, Lake Arrowhead:

Pediatric Cardiology, Aug. 16-19, 1959; *Emotional Problems in Office Practice*, Aug. 19-23, 1959; and *Internal Medicine*, Aug. 23-26, 1959.

ARIZONA'S LEADING OFFICE FURNISHERS AND DESIGNERS



Members of the medical professions are particularly invited to inquire about the details of our **LEASE** and **LEASE-PURCHASE** plans . . . the easy way to have attractive, efficient, comfortable offices and reception areas.

AL 3-5125

Walsh Bros. Established 1919

OFFICE EQUIPMENT

1636 NORTH CENTRAL

(just north of McDowell)

AMERICAN CANCER SOCIETY
CALENDAR NATIONAL MEETINGS

Date	*Meeting*	*Place*
June 1959		
8-12	American Medical Association	Traymore Hotel, Atlantic City, N. J.
15-18	American Proctologic Society	Shelburne Hotel, Atlantic City, N. J.
26-27	ACS Research Advisory Council	New York City
July 1959		
4-9	American Society of X-ray Technicians	Shirley Savoy Hotel, Denver, Colo.
22-23	Rocky Mountain Cancer Conference	Brown Palace Hotel, Denver, Colo.
23-30	International Congress of Radiology	Munich, Germany
August 1959		
4-7	International Association of Laryngectomees	Penn Sheraton, Pittsburgh, Pa.
10-13	National Medical Association	Detroit, Mich.
24-27	American Hospital Association	Statler Hotel, New York City
30-Sept. 4	World Conference on Medical Education	Palmer House, Chicago, Ill.
September 1959		
6-12	College of American Pathologists	Palmer House, Chicago, Ill.
7-12	World Medical Association	Montreal, Canada
11-12	International Congress on Air Pollution	New York City
13-17	International College of Surgeons	Palmer House, Chicago, Ill.
14-18	American Dental Association	New York City
28-Oct. 2	American College of Surgeons, Clinical Congress	Hotel Traymore, Atlantic City, N. J.
October 1959		
2-3	American Medical Writers' Assn.	St. Louis, Mo.
19-23	American Public Health Association	Convention Hall, Atlantic City, N. J.
23-27	American Heart Association Annual Meeting	Bellevue Stratford, Philadelphia, Pa.
26-28	National Rehabilitation Association	Boston, Mass.
November 1959		
19-21	ACS Scientific Review Committee — "Role of Viruses in Cancer"	Westchester Country Club, Rye, N. Y.
December 1959		
1-4	American Medical Association Clinical Meeting	Dallas, Texas
2-5	American Public Welfare Association National Biennial Roundtable Conference	Statler Hotel, Washington, D. C.
February 1960		
28-March 3	American College of Surgeons, Four-day Sectional	Boston, Mass.
March 1960		
13-18	National Health Council	Miami, Fla.
17-19	American Radium Society	Caribe Hilton Hotel, Puerto Rico
28-31	American Academy of General Practice	Philadelphia, Pa.
April 1960		
4-8	American College of Physicians	Mark Hopkins and Fairmont Hotels, San Francisco, Calif.

IN KABUL VERY FEW OVEREAT

On the contrary, the problem here in Kabul is *not enough* food!

Fighting hunger in places like Kabul is just one task of the UN's 19 Specialized agencies and international organizations. Elsewhere, UN teams combat floods, wage war against disease, fight illiteracy.

In these practical ways, the UN brings new hope and happiness into the lives of peoples less fortunate than we are—at the same time cuts down the discontent that could easily erupt into another war.

Your good will, understanding and support are the best guarantees of UN success. For the free pamphlet, "The UN in Action," address: United States Committee for the United Nations, Box 1958, Washington 13, D. C.

UN WE BELIEVE

ADVERTISING COUNCIL PUBLIC SERVICE

UNITED STATES COMMITTEE FOR THE UNITED NATIONS, BOX 1958, WASHINGTON 13, D. C.